VOLUNTARY ACTIVE EUTHANASIA: JUSTIFICATIONS AND REGULATIONS

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CONTENTS

CHAPTER 1

INTRODUCTION

Discussions on euthanasia have different aspects. Cases involve a wide variety of patients from terminally ill and competent to irreversibly damaged and in a coma. Regardless of the patient's diagnosis or current condition, euthanasia acquired an increasing importance when the medical means changed the period of approaching death. With the existing medical technology, the results can be as extreme as keeping a PVS patient alive for around 50 years[1] or keeping an ALS patient long after he lost every movement ability but of his eyeballs. In this study, I limit the discussion to a specific form of euthanasia, i.e. voluntary active euthanasia (VAE). By doing so, I focus on patients, who are competent, and on the procedure, which requires the doctor to administer a fatal substance to the patient.

In Chapter 2, I provide justifications for the regulation of VAE. In order to pursue the discussions on a logical ground, the relevant definitions should be clarified. These definitions include the subcategories of euthanasia and the

[1] Gregory E. Pence, *Classic Cases in Medical Ethics*, 4th ed. (New York: McGraw-Hill, 2004), p. 49.

differences between them, and the purpose of medicine. By presenting these definitions, I show that the proper understanding of euthanasia does not conflict with the aim of medicine; on the contrary the aim of medicine promotes the availability of the option of euthanasia. After defining these key notions, the main discussion is the moral value of VAE, evaluating two theses supporting the moral permissibility of VAE. The first one claims that there is no moral difference between voluntary active euthanasia and voluntary passive euthanasia –i.e. withdrawing or withholding the treatment. I reject this thesis on the basis of a consequentialist analysis. The second thesis justifiably argues that the moral value of a medical procedure is determined in relation to the "most appropriate treatment" in a given case and thus VAE is a moral procedure for certain cases.

In order to argue for the moral and legal permissibility of VAE, the important arguments in various areas –such as medicine, society and state– against VAE should also be considered. For this reason, I present the most widely used objections against VAE and show their weaknesses either to have a solid basis of principles or to have a realistic and practical approach to judging the current medical practice. Given these discussions, the conclusion confirms that VAE does not conflict with any fundamental principle of medicine –such as the Hippocratic Oath, the "Do No Harm" Principle, or the American Medical

Association Principles– or state –such as the “right to live” and the “right to die”–. In addition to that, current medical practice does not only provide a greater need for VAE but also causes many ethical controversies, which make it impossible to declare that VAE carries an extreme risk of abuses.

In Chapter 3, I move to the regulations of voluntary active euthanasia and physician assisted suicide (PAS). Since many arguments against euthanasia are based on the possibility of abuses in practice, it is crucial to discuss the existing guidelines in order to bring out the responses and prevent future slippery slope issues. As I explain in the first section, PAS can be categorized as a form of active euthanasia. Therefore the regulations and laws on both PAS and VAE form the body of this section. In order to point out the controversial conditions and the discussions about these conditions, I use the regulations of the Netherlands, Belgium, Switzerland and Oregon State. The conditions I evaluate are “unbearable suffering”, “constant and unbearable physical or mental suffering”, “terminal disease”, “no prospect of improvement”, “no selfish motive” and criteria for mentally ill patients and minors. These conditions are addressed as problematic for either being too narrow to include the patients who fit the aim of euthanasia, or being too wide to exclude the wrong type of patients. I provide the distinction between necessary ones –such as constant and unbearable physical or

mental suffering"– and sufficient ones –such as "terminal disease"– among these conditions in order to prevent the opposing arguments, which are based on the current practice of euthanasia.

CHAPTER 2

DEFINITIONS AND DISCUSSIONS

As technology progresses, many developments cause great improvements in the area of medicine. New means are found to prolong the patient's life and keep him/her alive, even if in some cases this means lowering the patient's quality of life. With the help of invented medicines and machines, as the patient is kept alive, the death and suffering of the patient is also extended beyond what was imaginable even 50 years ago. With these improvements, in the developed countries unhospitalized death rates have dropped drastically. 80% of the annual deaths in the U.S.A. take place in health-care facilities mostly after a decision to withdraw or withhold the treatment[2], whereas 80% of the deaths in the U.S.A. occurred at home 50 years ago[3]. This ratio shows that the timing and the manner of death is subject to more human interference than before, causing the discussions about euthanasia to become unavoidable. Although euthanasia has been performed and discussed since the time of Ancient Greece, the issue has

[2] Leon R. Kaas, *Life, Liberty and the Defense of Dignity: The Challenge for Bioethics* (San Francisco: Encounter Books, 2002), p. 201.

[3] Carolyn S. Roberts and Martha Gorman, *Euthanasia: A Reference Handbook* (Santa Barbara: ABC-CLIO, Inc., 1996), p. 33.

been in the spotlight for not longer than 40 years. The development of the artificial heart/lung machine to be used in surgeries (1952), the performance of open-heart surgery (1955), medically accepted usage of penicillin on patients (1955), and the development of the pacemaker for the human heart (1960)[4] formed a basis for preventing common deaths resulting from previously fatal conditions and procedures. These improvements have caused more people to face situations where their loved ones are suffering and the medicine which keeps them alive remains insufficient to alleviate their sufferings. Discussions on euthanasia have drawn public attention with famous cases such as Karen Ann Quinlan (1975) and Derek Humphry (1975)[5]. As medicine and law faced the necessity of dealing with cases that involve euthanasia, different categorizations of euthanasia have emerged and are used in order to form the regulations.

In certain countries including the United States and a number of European countries, under certain circumstances the practice of voluntary passive euthanasia –such as withholding or withdrawing the treatment– is considered as morally and legally acceptable, even though in most cases this procedure is preferred not to be categorized under the name of "euthanasia". The common way of carrying out the procedure of voluntary passive euthanasia is tagged under the

[4] Ibid., pp. 59–60.

[5] Ibid., p.63.

description of "avoiding unnecessary treatment" and is based on the idea of the patient's "right to refuse treatment". By not using the name of "euthanasia", these procedures are carried on with far less discussion, causing the practice to become a less controversial issue. On the other hand, the legal and medical systems of most of these countries –with the exceptions of the Netherlands and Belgium– are strongly against the performance of voluntary active euthanasia. There are many reasons given for this distinction and these reasons are based on various ideas about morality, medicine, social structure and the legal system.

In this section, I deal with the moral value of voluntary active euthanasia by limiting the discussion to competent patients and omitting the issues about euthanasia on incompetent patients such as infants, mentally disabled patients, and comatose or persistent vegetative state patients including the ones with a Living Will stating their preferences and requests beforehand[6]. I discuss the status of voluntary active euthanasia in contrast to the procedures which are considered to be morally and legally permissible under certain circumstances – such as voluntary passive euthanasia and terminal sedation– and which are found to be relatively less problematic –such as physician assisted suicide. I take the

[6] In this study, my aim is to focus on cases where the patient is presently competent and requests euthanasia. Even though Living Will is usually considered as voluntary euthanasia, there is always the discussion about what the patient would say if he had the chance to experience his present situation and decide in accordance with that instead of using imagination to state preferences. To avoid such discussions, which will not contribute to my study, I exclude such cases as well.

issue from the physician's, the society's, and the state's point of view in order to evaluate the moral status, logical implications and practical results of voluntary active euthanasia. To build further arguments on a stable ground, I start by defining different forms of euthanasia, the proper understanding of voluntary euthanasia and the aim of medicine. Then, I state the arguments against voluntary active euthanasia; and in connection with the analysis of these arguments I discuss different important aspects of the issue. These evaluations lead to the conclusion that voluntary active euthanasia is not only morally permissible, but it is also necessary considering the fundamental principles of medicine and state, as well as the problems faced in today's medical practice.

Definitions

Categories and Proper Understanding of Euthanasia

In exact translation, euthanasia –the combination of the two Greek words *eu* and *thanatos*– means "good death"[7]. The definition of euthanasia says that it is "the bringing about of a gentle and easy death for a person suffering from a

[7] Tom L. Beauchampand LeRoy Walters, ed. *Contemporary Issues in Bioethics*, 4th ed. (Belmont: Wadsworth Publishing Company, 1994), p. 434.

painful incurable disease"[8]. This general definition of euthanasia does not differentiate between the subcategories. According to this understanding, euthanasia includes any act that results in the patient's death and that is done in order to save him/her from the suffering caused by his/her medical condition.

Euthanasia is often differentiated into four categories: voluntary, non-voluntary, active, passive. Non-voluntary euthanasia is about patients who are not competent to make a decision because of various reasons including mental disability or being in a vegetative state. As I have stated earlier, discussions about euthanasia on incompetent patients will not be included in this study. Voluntary euthanasia is defined as when "a clearly competent patient makes a fully voluntary and persistent request for aid in dying"[9]. To clarify what this means, I say that the proper understanding of voluntary euthanasia indicates an act that occurs:

1. because of the patient's medical condition, which is found unbearable by the patient
2. in accordance to the patient's desires and values
3. with respect to a request by a competent patient

[8] *Oxford American Dictionary*, s.v. "euthanasia".

[9] Dan W. Brock, "Voluntary Active Euthanasia", in *Contemporary Issues in Bioethics,* ed. Tom L. Beauchamp and LeRoy Walters, 4th ed. (Belmont: Wadsworth Publishing Company, 1994), p. 490.

4. in order to end his sufferings

5. with the predicted consequence of death.

These conditions are necessary in order to claim that the act is a voluntary euthanasia. The first condition points out that the reason behind euthanasia must be a “medical condition” and it is not any medical condition, rather it is an “unbearable” one. The second condition claims that the scale to judge whether the medical condition is unbearable, or not, mainly depends on the “patient’s desires and values”. The third condition focuses on the “voluntary” feature of euthanasia, and therefore a “request by a competent patient” is essential. The fourth condition clears the aim of euthanasia and the fifth one refers to the result of the act.

These criteria form the necessary conditions to justify an act to be categorized under the name of “voluntary euthanasia”. This does not mean that meeting these five conditions is sufficient to justify the “process” of euthanasia, which has to be regulated by a strict and more detailed guideline in order to avoid abuses. For example, although we cannot argue that by definition euthanasia can be performed only by or with the help of a physician, to be able to regulate such a crucial procedure well, it would be reasonable to require the process to be carried out under a physician’s control as a necessary condition for

practice. Assume that a cancer patient who does not want to go through treatment and who is afraid of experiencing a lot of pain asks for help in dying and her husband, who is a nurse, injects a fatal drug causing her death. Since she makes the request for euthanasia because of her medical condition and in accordance with her desires and values, the case fulfills the necessary conditions of voluntary euthanasia. However, under a properly regulated procedure of euthanasia, the patient could have waited until the last minute, when the pain control treatment fails to relieve her sufferings, knowing that she will not be forced to experience unbearable pain. Therefore, although her case meets the necessary criteria, the act that is performed by her husband cannot be justified since such a crucial and irreversible procedure should be carried out by a physician, after the case is studied by a committee of experts to evaluate both her physical and psychological condition. Provided with such an analysis, her real need –in this case not to experience pain– can be satisfied instead of the conclusion she comes up with – which is to die now so that she can avoid the anxiety and possibility of experiencing pain. Hence, the five conditions that I have stated are only necessary but meeting them does not mean that the application of euthanasia can be justified in such a case.

There are two forms of voluntary euthanasia: active and passive. Voluntary active euthanasia (VAE) is defined as "when, at the request of the patient, a physician administers a medication or treatment, the intent of which is to end the patient's life"[10]. The most common form of VAE is to use a lethal injection that is given to the patient by the doctor. VAE is specifically important if the patient has limited capacity for movement as in ALS patients, which prevents them from swallowing a lethal substance by themselves. On the other hand, voluntary passive euthanasia (VPE) involves withholding, or withdrawing, the life prolonging medical treatment at the request of the patient. This occurs mostly if the patient is connected to a life-prolonging machine such as a respirator or feeding tubes, even though the definition applies to any life-prolonging medical treatment including medication or radiotherapy. Physician assisted suicide (PAS) is categorized either as a form of VAE –considering the cause of death– or as a third category next to VAE and VPE –considering the person who carries out the last act–[11] and is defined as "when a physician provides either equipment or

[10] The American Geriatrics Society. May 2007. "Physician-Assisted Suicide and Voluntary Active Euthanasia". Available [online]: http://www.americangeriatrics.org/products/positionpapers/vae94.shtml [September 21, 2007]

[11] Just as in the case of VAE, the cause of death in PAS is the substance that is given to the patient, unlike VPE where the cause of death is the disease itself. On the other hand, in VAE, the last act that leads to death is performed by the doctor, while in PAS, the patient carries out this last act even though the means are provided by the doctor.

medication, or informs the patient of the most efficacious use of already available means, for the purpose of assisting the patient to end his or her own life"[12]. The most important feature of PAS –and what distinguishes PAS from VAE– is that the act that leads to the patient's death is carried out by the patient himself. For example, if the lethal substance is a certain dose of barbiturates, then the doctor provides the means by prescribing the drug and the patient carries out the last act by taking the drugs.

When we look at the practice of medicine in real life, we see that VPE, such as not proceeding with any treatment for the patient's medical problem or removing the patient from the life prolonging machines or medicines, is more acceptable if the patient is incurable and decides to forgo treatment. On the other hand, the real problems arise when the situation involves PAS –e.g. a physician prescribing certain medicine and providing the information on how to use it in order to create a fatal effect– or VAE –e.g. a patient's request from her physician to stop her sufferings by injecting a lethal dose of medicine. With the exception of certain countries, being involved in PAS or VAE is illegal, although PAS is still considered as more understandable than VAE, because the physician does

[12] Ibid.

not perform the act of "killing" and death occurs by the free act of the patient himself.

Aim of Medicine

Considering that all these acts –i.e. VPE, VAE and PAS– are supposed to and commonly do involve physicians, it is reasonable to start by analyzing the aim of euthanasia and its relation to the aim of medicine. As I have emphasized earlier by stating the proper understanding of voluntary euthanasia, the aim of euthanasia is to end the patient's unbearable sufferings caused by his medical condition. Since it is a "last resort" procedure, euthanasia should be performed only if there is no other way consistent with the patient's values and desires of ending the patient's sufferings. These sufferings may be caused by an incurable disease, an irreversible injury, uncontrollable pain or very low life-quality that the medical condition forces the patient to live with.

When we turn to the aim of medicine, the definitions revolve around certain concepts such as "prolonging life", "health", and "healing". In 1928, Dr. William J. Mayo claimed in his famous quote that "the aim of medicine is to prevent disease and *prolong life*; the ideal of medicine is to eliminate the need of

a physician". This quotation leads to the idea of defining one of the main purposes of medicine as "prolonging" the life of the patient. Considering that medicine is an area where technological improvements have caused many serious changes, we have to keep in mind that some definitions are based on concepts which were used in accordance with their meanings and effects during the time when these definitions were created. Such concepts –and definitions which rely on these concepts– may have different attributions, which cannot be applied today. Before machines such as respirators, electric shocks or feeding tubes became common treatments, seeking ways to prolong a patient's life did not have the possibility of leading the patient to become dependent on machines or persistent painful medical procedures for the rest of his/her life. Although since the time of ancient Greece, physicians have had the ability to cure diseases which could otherwise lead to death, life-expectancy remained very low. The increase in life-expectancy occurred with the introduction of various medical treatments[13], at the end of the nineteenth and in the beginning of the twentieth centuries. For instance, in England life-expectancy rose only 6 years –from the age of 37 to 43– between the years of 1750 and 1880. However soon after, in 1900, it became 48

[13] The isolation of the tuberculosis bacteria (1882), the discovery of X-rays (1895), the opening of the first blood bank in the U.S. (1937), the development of the antibiotic streptomycin (1945).
Roberts and Gorman, pp. 57-59.

and by the end of the century, in 1998, the life-expectancy was 77[14]. As discoveries and inventions were made, the "life-prolonging" or "curing" treatments acquired a great amount of potential to add many years to human life. Today, although medical means help to save many lives, they also have the ability to keep a person alive but trapped in an unbearable situation, such as being totally paralyzed and having various tubes inserted into the body or suffering from a huge amount of physical pain with a certain knowledge that death will occur eventually but slowly. In that sense, it is reasonable to claim that the idea of "prolonging life" has gone through a change of meaning, where it not only means adding some years to the patient's life, but also means the high possibility of bringing decades of suffering and pain until finally medicine remains insufficient to keep the patient alive.

The second concept identifies the aim of medicine as providing "health". As claimed by Aristotle, "the end of the medical art is health"[15]. This idea of putting the notion of "health" at the center also gives rise to positions where it is claimed that the "promotion and preservation of health" should be the sole purpose of medicine by giving less importance to providing relief. According to

[14] Massimo Livi-Bacci, *A Concise History of World Population*, trans. Carl Ibsen, 3rd ed. (Massachusetts: Blackwell Publishers, 2001), p. 97.

[15] Aristotle, *Nicomachean Ethics*, trans. W. D. Ross, Book 1.1. Available [online]: http://classics.mit.edu/Aristotle/nicomachaen.1.i.html [21 September 2007]

this position, when the medical means remain insufficient to alleviate pain or terminate the suffering that is caused by the medical condition of the patient, then the case falls beyond medicine's scope[16]. In this sense, an ALS patient who can only move his eyeballs or a cancer patient who is in the late stages of her illness with uncontrollable pain is left to suffer since every medical means is already used but remains insufficient. Unless "health" only means the state of not being dead, medicine's purpose of protecting the health of people cannot be reduced to keeping patients alive no matter what the circumstances are. The World Health Organization's (WHO) definition of health, which is also accepted by the American Medical Association (AMA), states that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[17]. As this definition explicitly shows, patients who are alive but unable to move any part of their body other than their eyeballs or unable to breathe without respirators, cannot be called healthy. Given this, the definition itself constitutes an objection to the positions where "promoting health" seems to

[16] Daniel Callahan, "When Self-Determination Runs Amok", *Contemporary Issues in Bioethics,* ed. Tom L. Beauchamp and LeRoy Walters, 4th ed. (Belmont: Wadsworth Publishing Company, 1994), pp. 488–489.

[17] World Health Assembly. October 2006. "Constitution of the World Health Organization", p. 1. Available [online]: http://www.who.int/governance/eb/who_constitution_en.pdf [21 September 2007]

exclude alleviating the patient's suffering.

The last concept focuses on "healing", which is the most fundamental feature of medicine and provides the most reasonable definition for the aim of medicine. As Calman puts it, "the aim of medicine is to assist in the process of healing" and "doctors do this by improving quality of life, providing care, relieving suffering, promoting health, and preventing illness and disease"[18]. In this sense, medicine is mostly concerned about making the patient as comfortable as possible and providing the means to enable him to have the best possible quality of life either by fighting against the disease or by alleviating the pain. Given this idea, we can summarize the definitions as follows:

The aim of euthanasia: to end the patient's unbearable sufferings caused by his medical condition.

The aim of medicine: to improve quality of life, to provide care, to relieve suffering, to promote health, and to prevent illness and disease.

Promoting health and preventing illnesses and diseases are the social goals of medical practice, in order to prevent people from becoming "patients". Improving their quality of life and providing care do not help patients who request euthanasia, since those patients ask for this option because of the impossibility of

[18] Kenneth C. Calman, *Medical Education: Past, Present and Future: Handing on Learning*, (Edinburgh: Churchill Livingstone, 2006), p. 347.

acquiring an acceptable quality of life –according to their own values– and medical means remain insufficient to provide the necessary care that can solve their problems. Patients who have incurable diseases, or uncontrollable pains, have already passed the stages where medicine can give them some means to carry on their life. Only relieving suffering is suitable for those patients and the only way to do this is to provide the option of euthanasia. As this analysis shows, the aim of medicine and the aim of euthanasia have a common ground.

The Moral Value of Voluntary Active Euthanasia

With the help of these definitions, we can focus on the distinction between the accepted procedures such as withholding or withdrawing treatment, and voluntary active euthanasia. The general idea is that voluntary passive euthanasia can be morally acceptable under certain circumstances, while active euthanasia is always immoral[19]. The basic difference, which makes the passive euthanasia understandable but the active euthanasia not acceptable in many discussions, is that the passive euthanasia is seen as "letting the patient die" whereas the active euthanasia is seen as "killing". So it is "let nature take its course" versus

[19] Douglas Walton, "Active and Passive Euthanasia", *Ethics* 86, no.4 (July 1976), p. 343.

"committing a murder". Moreover, it is also argued that VPE is not a form of euthanasia but only the "appropriate medical treatment"[20]. If we look at the issue from the "*letting the patient die* as opposed to *killing*" perspective, it is clear why the active euthanasia causes a great deal more controversy than the passive euthanasia. However, if we analyze both VPE and VAE for their moral values, we see that with regards to applying the "appropriate medical treatment" there is no difference between the two procedures. In order to show this conclusion, I start by evaluating the moral values of both acts in terms of intentions and consequences, and then move on to their relation to the idea of "appropriate medical treatment".

To understand the morality that underlies VAE and VPE, we should understand the aim of them and how the consequences may differ in a given situation if one of them is considered to be always impermissible. In both VAE and VPE, the aim is to find a solution to fulfill the patient's request to end his sufferings caused by his medical situation. As an example we can suppose two scenarios: In the first case, the patient who is suffering from ALS is connected to the respirator, which keeps him alive. He decides to get the respirator removed in order to terminate his life to end his sufferings. This act will be choosing VPE,

[20] Bonnie Steinbrock, "The Intentional Termination of Life", *Morality in Practice*, ed. James P. Sterba, 5th ed. (Belmont: Wadsworth Publishing Company, 1997), pp. 160–164.

and under certain circumstances VPE is considered to be acceptable. In the second case, the same patient is not connected to any life-prolonging machine. His motive is the same as in the first case, which is to terminate his life. Yet this time, there is no life-prolonging treatment to withdraw. At this point his options are either letting himself starve, which is a long and painful procedure that cannot qualify as an "easy and quick death", or having a lethal drug applied to him by the physician, which would turn the situation into VAE. Since it is claimed that VAE is always immoral, he does not have a painless or a humane option.

Given the common aim of VAE and VPE presented in this example, it is not clear how these two processes differ from each other. The general way of distinguishing passive and active euthanasia relies on the process that takes place. The "immediate cause argument" claims that if the immediate cause of death is the disease, then it is passive euthanasia, and if the immediate cause of death is some other substance such as drugs, then it is active euthanasia. So, removing the life supporting machines, or not proceeding with any life-prolonging treatment, allows the patient to die from whatever disease he has; and therefore it is passive euthanasia. Providing a substance that will cause the patient's death, such as liquid potassium chloride, carbon monoxide gas or a

lethal dose of sleeping pills, causes the patient to die from whichever substance he has taken; and therefore it is active euthanasia. On the other hand, there are two procedures which do not fit this distinction: terminal sedation and physician assisted suicide. If the patient's disease requires a certain dose of medication to comfort him and to alleviate the pain, and if this dosage can also cause the patient's death, then even though the immediate cause of death is the medication, since it is given in order to control the pain, death is considered as a side-effect and accepted as the result of the disease; hence it is commonly categorized as passive euthanasia. Other than this, if the substance that is the cause of death is not applied directly by the physician –such as injection– but instead is given to the patient –like prescribing drugs– then it is categorized as "physician assisted suicide" and not as VAE even though the cause of death remains the lethal medication.

No Moral Difference Thesis

While arguing for the acceptance of VAE as a moral and legal practice, there are different theses that are supported by the defenders. The first thesis that I will consider is the following:

Thesis$_1$: There is no moral difference between VAE and VPE.

Although this thesis is based on seemingly good arguments, I will show that these arguments are not strong enough to withstand the objections.

Considering the "immediate cause argument", the distinctions between VAE and VPE are technical distinctions and it can be argued that in spite of such distinctions, there is no moral difference between them. In order to understand how we can clarify the moral values of these actions, we should get a general understanding of the basic morality theories. The most influential theories on ethics either take the intentions of doing an action or the consequences of that action into consideration to evaluate the moral value of that certain act. For example, let us take a case of a psychiatrist and his patient. The patient confides in the psychiatrist and tells him that he is still feeling very angry towards his ex-girlfriend. Confidentiality requires the psychiatrist to keep this information for himself and to try to help his patient to get over these emotions. Yet it turns out that before he can help his patient through, the patient goes and kills the ex-girlfriend. There are various ways to analyze the moral value of the psychiatrist's act. If we consider the psychiatrist's motives, his aim was to help his patient and without having his patient confiding in him, there was no way that he could build the trust to help him. Given this, breaking the confidentiality and letting the

police know about his anger may have caused him to lose the patient altogether and maybe even for no reason, since the psychiatrist did not see such a big threat in his emotional situation. The ethical theories that focus on the intentions of doing this act would categorize the psychiatrist's action as ethically right. His intention was to consider his patient's best interest, without taking the situation too far where others could be endangered. If we use Rule Utilitarianism, which says "we ought to do what would be prescribed by the rules with the best consequences for people in society to try to follow"[21], protecting the confidentiality unless there is a probable harm for other people would be for the best interest of the general public by giving them the trust to get professional help for overcoming their problems. On the other hand, when we focus on the consequences, there is Act Utilitarianism, which says "we ought to do whatever maximizes the balance of pleasure over pain for everyone affected by our action"[22]. In that case, since the consequence of the psychiatrist's act is one person murdered and one person in jail, it was a morally wrong action to take.

This example provides us the basis for evaluating all actions for their moral values. As the most widespread moral theories show, morality that is

[21] Ibid., p. 147.

[22] Ibid., p. 140.

attached to actions lies under the intentions and/or consequences of the action. Therefore, without getting into the details of any particular moral theory, I use a hybrid model that is based on intentions and consequences to evaluate the moral values of VAE and VPE[23]. In both the VAE and VPE cases, the intention is to let the patient have the power to choose whether s/he wants to live with his/her sufferings or not, and the consequence is the fulfillment of the patient's request that leads to his/her death. Whether the patient's request is fulfilled by removing a machine or adding an extra dosage of a drug is not relevant to the moral issue. Hence, within this restricted domain of intention and consequence based analysis, there is no moral difference between VAE and VPE. In his argument against the moral distinction between active and passive euthanasia, James Rachels argues in a similar way, claiming that when the act is done with the same motive and reaches the same end, then we cannot hold on to the technical differences to provide a moral distinction[24].

Although this argument seems to reach the conclusion given in $Thesis_1$, a more careful study shows its weaknesses. To begin with, we can go back to the

[23] Taking into account both intentions and consequences can cause conflicts in certain specific cases, where an evaluation based on intention-based account may give the opposite result to the evaluation of the same case through a consequence-based account. Such problems can be solved by a case-based analysis with the help of a hybrid model which captures the relevant aspects of both intention and consequence based moral theories.

[24] James Rachels, "Euthanasia, Killing, and Letting Die", *Morality in Practice*, ed. James P. Sterba, 5th ed. (Belmont: Wadsworth Publishing Company, 1997), pp. 154–155.

part of the analysis which focuses on intentions. Although both active and passive euthanasia share the same main goal of ending the patient's unbearable sufferings caused by his/her medical condition, the specific intentions of the actions change in accordance to the ways chosen to reach the main goal. When the doctor performs the VAE, her direct intention is causing the patient's death in order to end his/her sufferings. The process takes place when the doctor applies a fatal drug to the patient and the act results in the patient's death. On the other hand, in a VPE case, the direct intention is less apparent. In a case where the doctor disconnects the patient from the respirator, which keeps the patient alive, the intention of the doctor is the patient's death as a result of withdrawal of treatment. Here, we can talk about a direct intention of causing the patient's death, but on the other hand, in another case where the doctor stops the chemotherapy of a cancer patient, his intention may either be to hasten the predicted death of the patient or to terminate the useless medication to see how the illness will continue. So the result may be either the patient's death or a new set of treatments in accordance with the patient's condition. Given these situations, although both in VAE and VPE the main goal is to end the patient's sufferings, the direct intentions are not necessarily the same.

Rachels bases his argument, which has the conclusion of $Thesis_1$[25], on the American Medical Association's (AMA) statement that says the intentional termination of life is never permissible, but the "cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family"[26]. As Rachels takes it, this statement makes a distinction between active and passive euthanasia and the "cessation of the employment of extraordinary means to prolong the life" refers to passive euthanasia, which is permissible under certain circumstances. In that case, arguing for the moral equality of VAE and VPE puts VAE in a permissible situation as well. The strongest objection to this argument comes from Bonnie Steinbock, who claims that the AMA's statement is against any intentional termination of life –including active and passive euthanasia– and that the "cessation of the employment of extraordinary means" refers to the treatments that will not be beneficial for the patient[27]. This may be a chemotherapy that causes more damage to the patient, but after withholding the treatment the patient's condition may improve and the physician may decide that continuing with chemotherapy again may be for the

[25] Ibid., p. 151.

[26] Ibid., p. 152.

[27] Steinbrock, pp. 160–164.

patient's benefit. In such a case, "cessation of the employment of extraordinary means" does not lead to death and the physician's motives for agreeing to withhold these means are never about the "intentional termination of life"[28].

Using these cases, I claim it is reasonable to distinguish between withdrawing or withholding treatment clearly foreseeing the patient's death, and stopping the treatment to avoid non-beneficial effects. Considering this distinction, the example of the cancer patient would qualify for "stopping the treatment" (ST) where the doctor's intention is to avoid the damage or discomfort of the unnecessary treatment, and the example of disconnecting the respirator would qualify for VPE, where the intention is the same as with the VAE cases. It can be argued that there are cases where the doctor disconnects the respirator and the patient turns out to be able to adjust breathing without a respirator, or the doctor claims that the patient will certainly die without a heart by-pass surgery and the patient survives for years. First of all, there are many cases where such unexpected recoveries are impossible. For example, when the feeding tubes are removed from a patient who cannot get nutrition or hydration in any other way, it is understood that the patient will die because of dehydration. Or when a patient has complete kidney failure, unless she is connected to the hemodialysis device,

[28] Ibid., pp. 161-162.

it is understood that she will die because of the toxins. Hence, there are number of cases where the physician knows for sure that the patient cannot survive. Secondly, the possibility of "miraculous" recovery does not mean that the doctor does not predict death as a result of her action. When the doctor claims that according to her medical knowledge withholding or withdrawing the treatment will be followed by the patient's death, then it is reasonable to conclude that her intention and the most probable result of her action is the patient's death. If we make such a distinction, separating the ST cases from VPE cases by claiming that the predicted death of the patient is a necessary condition to call an act euthanasia, then ST should not be categorized under the name of "euthanasia"[29]. Given this distinction, $Thesis_1$ holds through an analysis based on intentions, since excluding the ST cases, both VPE and VAE share exactly the same intention.

When we move on to the analyses based on the consequences, the picture takes a different form. Keeping the distinctions of VAE, VPE, and ST, the consequences differ almost in every case. VAE provides a quick and painless death to the patient. In these terms, it is a humane procedure, which avoids the last second struggles that the patient may experience before death. It gives the

[29] There will still be cases which fall in the grey area between ST and VPE. But since it is still possible to make this distinction among many cases, I argue that making a separate category for ST cases brings a considerable clarification to the discussion.

patient the chance to have her loved ones around during her last minutes. However this definite and quick characteristic of the procedure has a downside. Once the act is done, there is no way back. On the other hand, VPE still provides some time for the patient to change her mind. For example, when the feeding tubes are removed, the patient still has the option of waiving her request and asking for the continuation of the treatment. Yet this time length also brings along many problems. The patient's sufferings do not end immediately with VPE, but she still has to go through a "non-peaceful" process of approaching death. If VPE is done through disconnecting the respirator, the patient experiences a feeling like drowning; and if VPE is done through disconnecting the feeding tube, the patient goes through a dehydration period which lasts ten to fifteen days and eventually leads to death. It is a very painful procedure and if the patient is made unconscious with certain medications such as morphine, then the advantage of VPE, which is giving the patient time to change her mind, diminishes. When it comes to ST, the consequences can vary as widely as death or some more good years. When the doctors decide that there is no suitable treatment for the patient, they stop the treatment without necessarily foreseeing the patient's death. As a result, the patient may die because of his illness, or without being exposed to the side-effects of treatments his condition may improve for new treatments, which

can eventually give him some relatively healthy years to live. Given these, an analysis based on consequences cannot claim that VAE and VPE carry the same moral value.

Most Appropriate Treatment Thesis

Although given the previous analyses about the moral statuses of VAE and VPE we cannot claim that they are morally equal, we can argue against this type of analysis by claiming that this moral difference does not come from the actions themselves. Bonnie Steinbock states that what the AMA intends to do is to provide the "most appropriate treatment" and this intention leads to ST, not VPE. On the other hand VAE and VPE are also medical procedures, which are supposed to be performed if and only if they are considered to be the "most appropriate treatment" for the patient by a committee of doctors. Hence a more plausible position to defend may be:

Thesis$_2$: Every medical action's moral value depends on its relation to the "most appropriate treatment". Therefore, VAE is not always immoral.

In a proper situation, when the patient asks for euthanasia, his medical condition

should not have the chance to be cured with any kind of medical means without causing him severe side-effects. If the patient is in un-controllable pain, asking for euthanasia comes after asking for the pain medication. If the patient is ALS or AIDS, asking for euthanasia comes after asking whether there is any cure for these diseases. If the patient has severe burns with irreparable damage, then asking for euthanasia comes after asking whether the treatment will help him fully recover and comparing the benefits of the treatment with the suffering that the treatment itself will cause. In any of these cases, euthanasia should not be performed when there is a more "appropriate treatment" available.

Claiming that both VAE and VPE are morally permissible does not entail that we can apply any one of them in any given situation. Obviously, applying VPE to a patient with a feeding tube –where the removal of the tube causes a long and painful death– morally differs from applying VAE to the same patient. This difference does not come from the acts or intentions themselves, but it is a result of choosing the right means. If VAE can provide a painless death where VPE cannot, then it would be moral to apply VAE and immoral to apply VPE. Likewise, if the patient wishes to experience a less "arranged" death and her pain can be controlled, then applying VAE instead of VPE to that patient cannot be justified. The same holds for choosing between surgery and medication. By

themselves, neither surgery nor medication has a moral value but they lead to moral discussions when we consider them in a given situation. Surgery is neither moral nor immoral, but if it is done to a patient who could have gotten well by a simple medication, then performing it will be immoral. Given this, we can claim that when we deal with the medical situations and the actions taken to handle these medical situations, the moral value comes from the idea of "appropriateness". Therefore, when VAE and VPE are performed as the "most appropriate treatment", their moral status does not differ.

Although I have argued that VAE is morally permissible, in order to make this view reasonably acceptable in practical life –which includes the society's opinion, legal regulations and medical rules–, we have to consider the arguments that are presented against VAE. Most of these arguments are about the impact of claiming VAE as morally permissible in practice, and the conflicts that arise between this claim and major principles. There are various arguments that are put forward against different aspects of VAE. I focus on arguments that discuss the issue from the physician's, the society's, and the state's point of view and then argue that VAE should not be accepted as an ethical and legal option.

Objections from the Medical Point of View

Principles

The first viewpoint I evaluate is the physician's role in VAE. It is argued that the physician's role can never be "killing" the patient, no matter what the circumstances are. The defenders of this argument base their position on three main sources: the Hippocratic Oath, the "Do No Harm" Principle and the AMA (American Medical Association) Principles. All of these sources are put forward by the opponents of VAE, claiming that they provide the basic rules for medical practice and VAE conflicts with these rules. To evaluate this argument, we need to look at these sources and see whether they really support the argument.

Hippocratic Oath

The ancient Hippocratic Oath makes the physician who takes the oath swear that he "will neither give a deadly drug to anybody if asked for it, nor will…make a suggestion to this effect"[30]. This sentence is used by the opponents

[30] Thomas A. Mappes and David DeGrazia, ed. *Biomedical Ethics*, 5th ed. (New York: McGraw-Hill, 2001), p. 66.

of VAE but since it still leaves room for VPE, to withhold or to withdraw the treatment is not seen as contradictory with this condition like active euthanasia. The Hippocratic Oath, which is seen as the foundation of medical practice, has many points where we find a huge distinction between what the oath says and what the accepted medical practice is. In 1964, the Hippocratic Oath was rewritten and this modern version started to be used in medical schools[31]. Many conditions of the classical version have been rephrased, changed or replaced with other conditions, or totally excluded in this modern version of the oath.

The first example I give to show the difference between the oath and today's medical practice is the sentence "I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work". With this sentence, the classical version excludes surgeons from the group of physicians that the oath applies to. However, in the modern version of the oath, this condition is rephrased as "I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug"[32]. A second example concerns abortion claiming that the physician "will not give to a woman an

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[31] Written by Dr. Louis Lasagna, Academic Dean of the School of Medicine at Tufts University.

[32] Association of American Physicians and Surgeons. "A Modern Hippocratic Oath by Dr. Louis Lasagna". Available [online]: http://www.aapsonline.org/ethics/oaths.htm [21 September 2007]

abortive remedy". This condition that prevents performing abortion is omitted in the modern version of the oath. A last example which clarifies the difference between the accepted medical practice and the oath is about monetary issues. The second paragraph of the original oath focuses on the physician's duty of teaching medical knowledge with no material benefits in return. This paragraph is as follows:

> To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art - if they desire to learn it - without fee and covenant…

In the modern version this part of the oath is changed as "I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow". It still preserves the idea of respecting and sharing the medical knowledge, but the clearly specified "teaching without fee" idea does not exist.

Given these changes, it is reasonable to think that the classical version of the oath has a traditional value and it is not a literal guide that can be applied in all times disregarding the changes that happened in the medical area, or in our own value systems. Also, we can assume that more changes will be needed as more improvements occur in medicine. Considering that the modern version of the oath was written before the euthanasia discussions became an important issue

and the conditions of the oath are subject to change, it cannot be reasonably argued that the sentence against active euthanasia is a binding condition for today's medical staff.

"Do No Harm" Principle

One of the arguments about euthanasia's incompatibility with the practice of medicine is based on the principle of "do no harm". Although the original source of this principle is unknown, it has been one of the fundamental traditional values of medicine[33]. It can be argued considering that causing death conflicts with this principle, which is a core value of medicine, euthanasia cannot be categorized or justified as a medical treatment. According to this idea medical treatments are done in order to provide the best support to the body to become as healthy as possible. In that case, death is the ultimate damage to the body and it is what the doctors should avoid most. However, this idea is based on the understanding of death necessarily as a form of harm. On the contrary, when we evaluate the cases where a competent patient asks for VAE, VPE or PAS, the decision is based on choosing the lesser harm.

[33] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001), p. 113.

First of all, for a patient to request voluntary euthanasia, she must be found competent to judge her situation and be fully informed about her condition to rationally decide on it. This means that through rational thinking, she is able to figure out what is most beneficial for her. Moreover, when a patient requests euthanasia, the thought procedure is to judge which option causes the least amount of harm to her. For instance, for a patient who is suffering from great pain in the late stages of cancer, which will eventually cause her to suffocate or bleed to death, to be alive is more harmful than having a peaceful death without going through this pain. In such a case, the patient judges that continuing to live is causing a greater harm than death. In addition to the patient's judgment on her condition, for her request of euthanasia to be fulfilled, there should be also other expert opinions supporting the patient's call. Under legal and proper regulations of euthanasia, the patient's case is examined by one, or more, consultant physicians to explore the treatment options, and psychiatrists to confirm her competence. When these experts agree with the patient's decision that death is not a greater harm in her condition, she is provided with help in dying. Given this, the physician who holds on to the principle of "do no harm" should help the patient die peacefully, if he wants to avoid harming his patient.

When we argue that euthanasia does not conflict with the principle of "do no harm" because of the suffering of the patient when she is alive, a conceptual argument rises. Generally, harm is considered to be an objective concept while the suffering is subjective, and therefore it can be claimed that we cannot justifiably argue against an objective concept using subjective ideas. This argument fails when we understand certain medical practices today. The most suitable example for this discussion comes from the field of plastic surgery. Certain plastic surgeries are done for medical reasons as well as accompanying aesthetic conditions. For example, when a patient wants to remove burn scars or a broken nose, the reason is caused by another injury. Likewise, when a woman wants to have a breast reduction surgery, the reason is usually both aesthetic and medical such as the backaches that she has been experiencing because of her breast size. On the other hand, there are plastic surgeries that are done completely for aesthetic purposes with no medical reason to support the procedure. These surgeries vary from simple rhinoplasty –nose surgeries– to liposuction. Each of these cosmetic procedures carries a risk, which can be very low or very high in accordance to the type of procedure (or procedures) and the health condition of the patient. Since none of such procedures are justified through medical reasons, we can claim that the doctor is causing harm to the

patient by risking his health and even his life. Considering that these surgeries are legal and commonly performed, it can be argued that the medical experts do not define the notion of "harm" as completely objective. On the contrary, "harm" includes certain subjective values –such as the patient's suffering caused by his dislike of a particular part of his figure– as well as objective ones such as pain. I examine the idea of "suffering" in more detail in the third chapter of my thesis, but as far as the "do no harm" principle is concerned, we can claim that in the medical area, the principle is interpreted in such a way that it includes subjective sufferings as well as the objective pain.

American Medical Association Ethics Principles

As opposed to the ancient and traditional principles like the Hippocratic Oath and the "Do No Harm" Principle, the AMA Ethics Principles aim to provide a guideline for medical practice today and they are widely accepted. Although the AMA has a long history of opposing both to passive and active euthanasia on different levels, I argue that these fundamental ethical principles do not oppose or conflict with the aim of euthanasia, which is to let the patient have the final decision about his own life and death considering his medical situation. There are

nine conditions in the AMA's Principles of Medical Ethics. Here, I consider the ones which are most relevant to the discussions on euthanasia among them.

A- 1st Principle:

The first principle states: "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."[34] The proper understanding of voluntary euthanasia is based on the idea of respecting the patient's right to self-determination, his right to have full control about the decisions concerning his own life and body. When the medical means remain insufficient to find a cure for the patient's medical condition, the physician should not abandon the patient but instead he should apply the most appropriate treatment to provide comfort.

Physicians who attend the cases of terminally ill patients should base their judgments on "the most important values that underlie the care of the dying – values of informed personal choice, minimizing suffering, and non-abandonment"[35] as well as the cases of non-terminally ill but incurable patients – such as ALS patients. These values do not leave an option for the medical attendants to leave the patient to die or to suffer alone. These same values open

[34] American Medical Association. June 2001. "Principles of Medical Ethics". Available [online]: http://www.ama-assn.org/ama/pub/category/2512.html [21 September 2007]

[35] Timothy E. Quill, *Death and Dignity: Making Choices and Taking Charge* (New York: W.W. Norton & Company, 1993), p. 20.

the door for VPE, VAE, and PAS, when the suffering of the patient cannot be minimized while keeping the patient conscious or alive.

A famous example of such a situation is Dr. Timothy Quill's patient Diane. Diane was an acute myelomonocytic leukemia patient who decided not to go through any treatment for her condition. Her decision was based on her previous experience with cancer and the statistical data of the probability for her survival. She had a difficult personal history, where she survived alcoholism, depression, and vaginal cancer, and managed to turn her life around to become successful both in her business and in her personal relationships with friends and family –including her husband and son. She had "a strong sense of independence and confidence" and facing cancer a second time, she decided that she did not want to go through the painful treatments. Her values made it impossible for her to accept losing her independence and that caused her to plan her "arranged" death. Dr. Quill, who had been Diane's doctor for a long time, participated in her PAS by prescribing her the barbiturates that she needed to take. By doing so, he was able to make sure that she waited until the very end of her respectively healthy days and she did not need to worry about losing her independence[36]. In

[36] Timothy E. Quill, "Death and Dignity: A Case of Individualized Decision Making", *Contemporary Issues in Bioethics*, ed. Tom L. Beauchamp and LeRoy Walters, 4th ed. (Belmont: Wadsworth Publishing Company, 1994), pp. 479–481.

such cases, providing the option of PAS, VPE or VAE is the "best available and most appropriate treatment" to respect the patient's decision and minimize her suffering, even though this means providing a painless death. Hence, the competent medical care that the doctor should provide with respect to the patient's dignity and right entail the application of voluntary euthanasia under certain circumstances.

B- 8th Principle:

As we move on to another article in AMA's Ethical Principles, the guideline states that: "A physician shall, while caring for a patient, regard responsibility to the patient as paramount."[37] This principle supports the idea that the physician's primary role is to focus on the benefits and the harm of the situation that affects the patient. Since voluntary euthanasia relies on the patient's self-determination and is based on the patient's personal values, focusing on the patient's benefits enables the physician to consider every possible way to cure or minimize the sufferings of the patient. Given that in certain cases, the continuation of the suffering and harm can only be avoided by permitting euthanasia, any doctor who believes in this principle would consider himself responsible for giving his patient this option.

[37] American Medical Association, "Principles of Medical Ethics".

C- 3rd Principle:

The last article that I would like to consider is the one that says: "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient."[38] The arguments that I have given so far aimed to show that under certain circumstances, voluntary euthanasia is for the patient's benefit and since it results from a medical condition, it falls under the physician's duties to consider this option when it is requested by the patient. As I have shown under the section of the "do no harm" principle, justified euthanasia cases are the ones where death is a lesser harm for the patient's condition. In a case where the available treatments are not sufficient to let the patient have a certain level of health and quality of life, the doctor has to choose the most appropriate way of ending the patient's sufferings. The options can vary from ST and VPE to PAS and VAE, in order to apply the proper treatment for each different case. Given these ideas, this last article of AMA's Ethical Principles encourages doctors not only to consider euthanasia but also to take responsibility to make this option available for their patients even if this means to "seek changes" in the legal system.

[38] Ibid.

To clarify the understanding of this principle, we can go back to the case of Dr. Quill and Diane. As a person deeply attached to her independence, she decided to remain in control of her life and not to become dependent[39]. This decision meant that she would be planning when and how to die, but none of these are easy to plan without sufficient knowledge. If Dr. Quill had not helped Diane, she would have been spending her last days worrying about her death and maybe, misjudging the right timing, she could have killed herself too early. Getting help from Dr. Quill enabled her to make the most of her last months and to get treatment for the curable discomforts –like infections– caused by her condition[40]. The "best interest" of Diane was provided with the help that she was given for her decision, not through neglecting her values and pushing her to lose her independence or to take care of her own situation. Recognizing the needs of such patients, the law should include voluntary euthanasia to support the "best interest" of the patients and this principle requires physicians to acknowledge their responsibility in such legal issues.

[39] Quill, "Death and Dignity: A Case of Individualized Decision Making", pp. 479–481.

[40] Ibid.

Killing vs. Letting Die

Another argument in this area deals with the distinction famously made between "killing" and "letting die", in the sense that the former presents an action while the latter is only an omission. Hence, a physician can never kill but he can "let nature take its course" and let his patient die from whatever disease he has. In this argument taking an action –i.e. killing– is presented as the procedure for active euthanasia and omitting –i.e. letting the patient die– is given as the procedure for passive euthanasia, claiming that killing is always immoral while letting the patient die may be morally acceptable in certain cases[41]. A conceptual distinction between them can be stated as "*killing* is causal action that brings about death, whereas *letting die* is the intentional avoidance of causal intervention so that disease, system failure, or injury causes death"[42].

At this point we have to analyze passive euthanasia, active euthanasia, and physician assisted suicide more deeply. Passive euthanasia has two forms:

[41] Assuming that the AMA means ST while claiming that withdrawing or withholding treatment can be morally permissible under certain circumstances, in this specific discussion I refer to the cases of VPE by excluding the cases of ST. Hence, stating that VPE is found to be morally acceptable in certain cases does not point out to the AMA's distinction, but rather indicates the general idea of distinguishing between active and passive euthanasia, and killing and letting die.

[42] Beauchamp and Childress, p. 140.

withholding or withdrawing the treatment where the lack of treatment leads to death. For example, if the patient has a heart condition where the absence of surgery definitely leads to death, and if he refuses to have this operation, then the doctor may withhold the treatment and without performing the surgery he can let him die. Another example of passive euthanasia may be a case where the same patient goes through the surgery and as the result, he survives but after the surgery he has to be connected to the respirator since he is unable to breathe by himself. When he wants to terminate his life, the doctor withdraws the treatment by turning off the respirator. From these two cases, we can see two important points. One, although in the first case –where the doctor withholds treatment– we are faced with an omission, in the second case –where the doctor withdraws treatment– there is definitely an "action" involved, which results with "death"[43]. Considering that *killing* can be defined exactly as "causal action that brings about death", we can reasonably argue that this case can qualify as killing. Two, although in the first case where the patient's disease is not treated at all we can talk about the disease killing the patient, in the second case we cannot talk about death as the result of only the disease itself, considering that the respirator was connected after the surgery and because the medical condition occurred as the

[43] David Orentlicher, "The Supreme Court and Terminal Sedation", *Physician Assisted Suicide: Expanding the Debate.* ed. Margaret P. Battin, Rosamond Rhodes, Anita Silvers (New York: Routledge, 1998), p. 302.

result of the surgery. Therefore, in this example, the death following the withdrawal is not caused by the disease but it is caused by the medical treatment. This means that we cannot call it an "intentional avoidance of causal intervention", i.e. *letting die*.

On the other hand, PAS and VAE are distinguished in accordance to the person who performs the last act. In other words, it is considered in PAS when the physician prescribes the drugs for the patient to commit suicide that the physician is only assisting and the last act, which leads to death, is carried out by the patient by himself. But when we evaluate VAE, it is claimed that since the physician's causal action results with the patient's death, it is categorized as "killing". With these definitions and the heart surgery examples, we can change this categorization. When the physician does not perform the surgery, there is no action involved; and when the physician prescribes the medicine with explicit directions to how to use them to cause death, the action does not directly lead to death because there is still a last step to be carried out, which the patient may or may not perform. Given this we can conclude that neither withholding the treatment nor PAS is *killing*. On the other hand, when the physician disconnects the respirator and when the physician applies a fatal drug, there is an action which directly and intentionally causes the patient's death. Hence, given the

description of *killing* as a "causal action that is performed by the physician and directly brings about death", both withdrawal of treatment and VAE falls under the same category. Therefore, it can be argued that if the distinction between "action" and "omission", "killing" and letting die", or "human interference" and "nature's course" should be preserved, then passive euthanasia can only be understood in terms of withholding the treatment, and withdrawal of the treatment does not fall within this scope.

This idea can lead us in two different ways. One way is to claim that since the conclusion shows that withdrawal is also a form of "killing", we should simply consider it as immoral as well. This approach is adopted in many countries –including Turkey– claiming that any act that leads to death –whether it is VPE, VAE or PAS– is considered to be immoral and illegal. The Turkish Medical Deontology Regulations and Patient's Rights Principles prevent any form of euthanasia. Although there is no article about euthanasia in the Constitutional Law, it is interpreted as categorizing any form of euthanasia as deliberate murder; and in court, both passive and active euthanasia (voluntary or not) are considered as homicide. The Turkish Deontology Regulations say that doctors cannot perform any act that does not aim at diagnosis or treatment and

that will harm the body's endurance, even if this act is requested by the patient[44]. The Turkish Patient's Rights Regulations state that euthanasia is impermissible and no matter what the reason is, the right to life cannot be waived. Neither with the patient's nor with someone else's request, can life be ended[45]. The treatment can be withheld, and it can be withdrawn unless the withdrawal causes medical harm[46], hence classifying the withdrawal as VPE –i.e. with an intended and predicted result of death– is not permissible. Given this information, in certain legal systems not only are VAE and PAS illegal (which is the common situation around the world), but also the patient's right to refuse treatment is overridden unless the case is specifically ST. Patients suffering from diseases such as ALS, cancer, and AIDS are left to struggle by themselves when the medicine is not sufficient to provide the necessary means to improve the patient's condition or alleviate her pain. Whether it involves VPE or VAE, as claimed by Quill, it is the physician's duty not to abandon the patient and to provide the best care. Neglecting the patients for whom the medicine remains insufficient to cure or to alleviate the pain means that doctors abandon their patients, when they decide

[44] Tıbbi Deontoloji Nizamnamesi, Madde 13. (Medical Deontology Regulations, Article 13). Available [online]: http://www.tyih.gov.tr/HASTAHAKLARI/ulusalm1.php [21 September 2007]

[45] Hasta Hakları Yönetmeliği, Madde 13. (Patient's Rights Regulations, Article 13). Available [online]: http://www.tyih.gov.tr/HASTAHAKLARI/ulusalm2.php [21 September 2007]

[46] Ibid., Madde 24. (Article 24).

there is nothing else they can do. Since the patient's suffering does not end at this point, the doctors should keep providing the most appropriate treatment for their patient's medical condition. Forcing patients to remain alive through various medical procedures where none of these medical procedures can improve her condition or reduce her pain, is compatible neither with the aim of medicine nor with the right to self-determination.

On the other hand, there is a second way that this argument of distinguishing between moral and legal values of actions based on "killing" and "letting die" can lead us. This approach is to claim that since defining passive euthanasia only as withholding the lifesaving treatment leads to a crucial limitation of the right to refuse treatment and the right to self-determination and conflicts with the aim of medicine, we cannot base our distinction on such an argument and assign moral values by using it. Given this, we can conclude that the "killing" and "letting die" distinction does not give a strong argument either for making a moral and legal distinction between VAE and VPE or for claiming that both forms of euthanasia should be impermissible.

Objections from the Social Point of View

Some opponents of active euthanasia argue that allowing VAE will cause major problems in the social order. They claim that although it may be beneficial for individual cases to have the option of VAE, for the well-being of society active euthanasia should remain impermissible[47]. The first group of arguments for this view focuses on low-income, uneducated people and minority groups. One argument suggests that poor people who do not have a chance to choose a better treatment will choose to die, just because they will not want to suffer even though their pain would have been treatable if they had the money to pay for better medical care. In this sense, it is argued that instead of legalizing euthanasia, medical care should be improved to prevent the abuse of vulnerable patients. Legalizing euthanasia would be providing an answer for the problems that could have been solved by better medical care and many patients who could have survived may become subjects for euthanasia. This argument can be answered from three aspects. First of all, there are many cases where euthanasia is the only answer even though every means that medicine can provide is used. Medicine itself has limits and providing the best possible medical care does not

[47] David Orentlicher, *Matter of Life and Death: Making Moral Theory Work in Medical Ethics and the Law* (Princeton: Princeton University Press, 2001), p. 12.

necessarily lead to the solution where the patient's sufferings are eased and his request for euthanasia is willingly withdrawn by himself. Keeping euthanasia illegal for the sake of protecting patients with solvable problems from unnecessary requests for death does not help the ones whose only solution is euthanasia regardless of the level of medical care provided. Moreover, neglecting the needs of these patients who have no other option pushes them out of the scope of medicine and shows that at this point, they are not even a part of the medical system.

The second response to this argument is about the practical situation and real life. Ideally, if there is a solution in the realm of medicine for the patient's suffering, it should be provided and the patient should not have a need to look for other options including euthanasia. This ideal situation is not impossible and it can be created through a well-formed health care system, which makes sure that every patient will get the ultimate care. However, in real life, many countries lack this care system and patients are left to struggle as long as they can financially afford it. For example, many poor people living in United States do not have health insurance which will cover all their medical problems and provide every possible medical care to make them comfortable if the condition is incurable. In reality, a poor paralyzed cancer patient at the late stages of the

sickness with no one to take care of her has only one option: living with her condition. If she finds her condition unbearable, her option remains the same: living with her "unbearable" condition. We cannot know for sure whether she would request euthanasia even if she is put in a care house where all her medical needs are met and where her quality of life is kept higher. Yet unless this option is provided, leaving her with only one choice –i.e. suffering– is not better than leaving her in a situation where she has to choose between suffering and euthanasia. Considering that even when the political agendas place the improvement of the health-care system at the top of the list the actualization of this plan would take years, taking away the option of euthanasia does not serve for the benefit of the people who need it most.

Thirdly, this argument argues against euthanasia by considering the harm that possible underdevelopment of health care system may cause to vulnerable patients. Given that the development of the health-care system and legalization of euthanasia are not mutually exclusive, arguing against one by defending the other one does not provide a strong objection. Although euthanasia will serve its purpose better under the conditions of a fully developed health-care system, this does not lead to the conclusion to keep it illegal until the development is completed. This situation is true for any invasive and irreversible medical

treatment. Let us take an example from dental medicine. In a country where there is no dental means to treat cavities in teeth, people will have extreme pains and inflammation in their mouth. Having removal of a tooth as a solution would not be desirable, considering that many people who could have kept their teeth with proper treatment will end up losing them. On the other hand, allowing the removal of the tooth has no bearing on the development of dental medicine. It is not reasonable to keep the patient stuck with the tooth pain with the hope that maybe the means for cavity treatment will reach the country. Given that the development of medicine and the practice of tooth removal are not mutually exclusive, even though it is not the best solution, patients with "unbearable suffering" should be suitable for any treatment considering that they are not in a condition to wait for the potential options. Hence, since advocating better health care and providing the option of euthanasia do not conflict with each other, this idea cannot provide a strong argument against euthanasia.

Another argument claims that since these people are not well educated, they can be subject to manipulation, and the medical and legal system may end up giving the institutions the chance to get rid of the patients who do not have the means to pay for the treatment. In that case let's take an example where a poor, old, and uneducated woman is manipulated by the institution to choose VAE

since they realize that she is not going to be able to pay for her medical expenses. Assuming that she can be manipulated in this way, it is even easier to manipulate her in many other easier ways such as disconnecting her from any life prolonging machine, stopping life prolonging medication, simply convincing her to go back home saying that there is nothing else the hospital can do for her, or not performing a life saving surgery. If an institution has the power to convince certain patients to choose death, it is reasonable to think that it would be even easier for them to convince the patients to stop treatment and get discharged from the hospital, to ask for withdrawal of life-prolonging treatments even if the treatment is highly beneficial for them, or not to go through a necessary surgery by falsely claiming that the surgery cannot be beneficial for them. Likewise, doctors can abuse the patient by performing highly risky and unnecessary surgeries in order to earn more money. When it comes to abuses that can lead to the death of patients who can be saved, this danger holds for many cases in medicine. However, we cannot reject medical treatments on the basis of potential abuse; instead this risk of abuse only puts these treatments in a status where they should be regulated through careful and strict guidelines.

A last argument of this group suggests that vulnerable people such as the elderly may end up choosing death either because they are ashamed of being a

burden to their family where the VAE option is available for them or because their relatives may try to take advantage of them, such as getting the money from their life insurance, by leading them to death. Here, again, we can use a different medical procedure as an example to clarify the situation. Organ transplant is one of the medical treatments that are highly risky and critical in many cases. On the other hand, the illegal organ trade causes damage as serious as death to many poor, uneducated, and/or weak people. Just as in the previous argument, the options in such a situation should not be to let the disadvantaged people be abused or let the patients suffer by criminalizing organ transplantation. The focus of this problem is how to regulate this procedure so that the harm can be prevented. The same goes for the euthanasia argument. The answer for the problem that the objection provides lies in regulation. Defining the regulations for the proper function of a procedure is the only way to help the ones who are in need of this option and who should not get abused on the way. In other words, certain medical procedures are more open to abuse because of their critical, risky, and/or irreversible nature. If these procedures are the "most appropriate treatments" to deal with the patient's sufferings, then the solution to avoid abuses should not be to prohibit these treatments. Instead, the solution should be to make the regulations strictly for the benefit of the ones who need these

procedures by preventing the application of them to “inappropriate” patients for “inappropriate” reasons.

To sum up, these types of objections are not restricted to VAE, but they are already present for the unprotected and vulnerable patients who die or suffer because of poorly developed medical systems that fail to give full support and protection to every individual. The objections are based on the abuse of VAE, but the answer does not lie in rejecting the legalization of VAE. Rather, the answer should be provided by proper regulations of euthanasia. For that reason, even though there is no guarantee that VAE will not be misused, we take the same chance by letting doctors perform highly risky surgeries, where sometimes unnecessary surgeries are done just for financial benefit, or by letting people have the right to refuse treatment where sometimes abuse of this option may cause people to end up giving up treatments that could have saved their life with no further complications. In order to provide the availability of the most appropriate treatments, development of a full health care system is important, but this idea does not lead us to claim that we should delay the legalization of many crucial procedures like euthanasia.

Objections from the State's Point of View

The Right to Die

The last set of objections is concerned with the state's role in legally accepting VAE as a medical procedure. The first issue is on the idea of a "right to die". While VPE can be based on a right to refuse treatment, which is widely accepted by most countries' moral and legal systems, it is not possible to justify VAE and PAS on the same basis. The right to refuse treatment relies on the idea that every person has the right to be free from unwanted interventions made to his/her body. On the other hand, VAE and PAS refer to actions deliberately done to cause the patient's death. Therefore, it is argued that these actions should be based on a "right to die", but from the moral stance it is highly controversial whether people have such a right. Moreover, most countries' legal systems reject the idea of the existence of a "right to die". Given these points, VAE and PAS seems to be unjustified both morally and legally.

First of all, the basis for the idea of a "right to die" comes from the *right to self-determination*, which can be defined, as stated in a New York Court of Appeals decision in 1914, as the principle that "every human being of adult years

and sound mind has a right to determine what shall be done with his own body"[48]. If the person has a right to be the decision-maker about her own body and life, unless her decision is irrational or harming other parties, terminating her life cannot be viewed as outside of the scope of the right to self-determination. The cases in which the state interferes with the person's right to self-determination, are when her mental stability and decision-making capacity is in question –i.e. being caught committing suicide– or when other people are endangered –i.e. getting an abortion after the fetus develops to a certain level or having a contagious disease. In most euthanasia cases none of these conditions hold, since the patient is found to be competent already and her action is only about her own body. Of course there are certain cases where euthanasia can be harmful for third parties, but these can be regulated under a clearly defined guideline.

Another response to the arguments against a "right to die" is that having a right gives us the option to use or to waive this freedom. For example having a right to speak does not force us to speak, but it gives us the freedom to choose

[48] Jerry Menikoff, *Law and Bioethics: An Introduction* (Washington: Georgetown University Press, 2001), p. 156.

whether to speak or to be silent[49]. Hence, claiming that every person has a "right to live" necessarily leads to the acceptance of every person's "right to die". Yet, since "moral rights are usually held to be correlative with moral duties"[50], the patient's duties affect her justification to use her rights. So, when we apply this idea to the right to die, we can say that the limits of a person's right to die are defined by her overriding duties. In that sense, for example an eight month pregnant patient has an overriding duty to live because of her duty to respect the right to live of her child. Although the right to die can be derived from the right to live, it does not have a traditional and historical background that clearly defines it. Yet the same goes for the right to remain silent or the right to not own property. Therefore, even though it is not clearly specified in most legal systems, the right of a patient to choose death can be justified given both the right to live and the right to self-determination.

Right to Kill

Another argument is that even though the fundamental principle of a

[49] Rosamond Rhodes, "Physicians, Assisted Suicide, and the Right to Live or Die", *Physician Assisted Suicide: Expanding the Debate.* ed. Margaret P. Battin, Rosamond Rhodes, Anita Silvers (New York: Routledge, 1998), p. 166.

[50] Ibid., p. 167.

right to live may be compatible with the idea of a right to die, it is still conflicting with a right to kill. In other words by accepting VPE, the state accepts a patient's right to die, which results from intentionally or predictably letting the patient die by relying on his right to refuse treatment. However, it is argued that letting VAE be permissible means that the state also allows doctors to have a right to kill, which is not compatible with the basic understanding of the right to live indicating that no person can kill another individual because every human being has a right to live.

One defense against this argument can be given again by using the withdrawing and withholding distinction. As I have stated earlier, the act of withdrawal of a life prolonging machine can be seen as "killing" as well. Therefore, if we are to make a distinction between "right to die" and "right to kill", then we need to categorize withdrawal of treatment as a form of killing as well. As I have already argued, since making such a categorization leads to unacceptable consequences, the argument based on the distinction of "killing" and "letting die" does not provide a strong objection.

A second defense may rely on the idea of "assistance". The state's duty is to preserve its citizens from any harm including physical damage caused for example by a knife. A person who cuts someone's chest open is considered as a

criminal and a subject for punishment. On the other hand, many highly risky heart surgeries require the chest of the patient to be cut open and in that case no legal authorities find the doctor guilty of a crime, even if the patient dies on the table. The reason for this difference is that the aim and the intention of the doctor are to assist the patient in reaching his goal, which is to have a heart surgery and to pursue a healthy life. Since the patient cannot perform this medical procedure himself, the doctor provides her assistance. The same procedure works in VAE as well. The goal of the patient is to end his sufferings caused by his medical conditions and since he cannot perform this procedure competently, he asks for assistance. In that case, the doctor cannot be blamed for killing the patient, just as the surgeon cannot be blamed for cutting the patient's chest open, even if this act results with the death of the patient which is the opposite of the patient's main goal.

Regulations

Another objection against VAE from the state's point of view claims that it is not only difficult to create regulations, but it is even a harder job to enforce such regulations in such a crucial procedure. Therefore, it is more reasonable to

prevent the procedure altogether to keep the abuse rate as low as possible. Contrary to this argument's claim, in practice, ignoring the need and the option of VAE does not lead to less abuse. Either people suffer severely through the last stages of their illnesses or they look for loopholes and find ways to get around the laws. One of such procedures is "terminal sedation", where the patient is given a certain dose of medication that shuts down her consciousness. Under terminal sedation, the patient either dies from the disease or from dehydration. Leaving the questions about its moral value or effectiveness aside, terminal sedation is providing a higher risk for abuse because of the lack of the necessary attention given to the process. Since terminal sedation is considered to be a part of the usual medical procedures, there is less attention drawn to the issue compared to euthanasia. This situation causes the cases involving terminal sedation to be less controllable than the cases involving euthanasia[51]. Since there are no guidelines and regulations controlling the use of terminal sedation, it is possible for the doctor to apply terminal sedation without consulting any other physician or for nurses to apply it with the doctor giving the order without even checking on the patient himself. This shows that neglecting the needs and

[51] Orentlicher, "The Supreme Court and Terminal Sedation", pp. 301–311.

suffering of patients does not protect them; on the contrary it results with procedures which are even more open to abuse or misjudgments.

A counterexample to the idea of non-legalization of euthanasia for the sake of preventing abuses and slippery slope is the case of Dr. Kevorkian. Dr. Kevorkian is a pathologist, who specialized in the area of autopsies. He helped 38 patients to kill themselves with a machine he invented, to which he connected the patient, but since the last act of pushing the button was done by the patient, Dr. Kevorkian's act falls within the category of physician assisted suicide. Dr. Kevorkian did not have any long-term relationship about his patients, he did not consult other physicians on the patients' conditions, and he did not explore and explain every other possible treatment[52]. Given that these patients were desperate to seek help, instead of being advised and assisted by a committee of doctors to judge their physical and psychological conditions, they had to turn to a non-practicing doctor who agreed to assist them. Another example on this issue can be the practice of "slow code", which refers to "cardiopulmonary resuscitative efforts intentionally conducted too slowly for resuscitation to occur"[53]. Slow codes occur when the medical staff agrees to act slowly to save the patient's life,

[52] Roberts and Gorman, pp. 92–93.

[53] Jacinta Kelly, "Literature Review: Decision-Making Regarding Slow Resuscitation". *Journal of Clinical Nursing*. February 2007. Available [online]: http://www.blackwell-synergy.com/action/showFullText?submitFullText=Full+Text+HTML&doi=10.1111%2Fj.1365-2702.2006.01781.x [21 September 2007]

even though there is not a do-not-resuscitate order given by the patient. Although it is almost impossible to attain statistical data on such procedures, they remain morally controversial because of the lack of the patient's autonomy, the family's knowledge, and maybe even a consultation with other doctors about this decision. As we can see from such real-life cases, both for the state's and society's benefit, it is most reasonable to form and apply legal regulations which meet the needs of suffering patients in order to avoid abuses and to give the best care.

As I argue, any type of euthanasia requires a carefully determined strict guideline to eliminate abuses. Given this, prohibiting euthanasia and leaving such other ways around is causing the state to have less control over such crucial treatments, which are basically euthanasia in disguise. This hypocritical approach to the issue causes more damage and makes fatal acts, which should be considered as euthanasia and which should be carefully and strictly regulated, more open to abuse.

Conclusion

As medicine improves and the concepts of health and death get more complicated, euthanasia turns into a morally and legally accepted medical

procedure in certain countries. But so far, medical and legal systems in most countries draw a line between voluntary active and passive euthanasia, letting only the latter be permissible under certain circumstances. This understanding results from the idea that even though there can be certain cases where VPE is appropriate, VAE can never be considered as morally acceptable. Although we cannot claim that VAE and VPE are morally the same, we can claim that as far as the "most appropriate treatment" is concerned, VAE has a status which is equal in importance to any other critical medical procedure. There are many arguments against the morality and application of euthanasia. However, evaluating them, it can be reasonably concluded that the ethical complications that seem to arise in VAE are no different than the ones that are faced in other critical, invasive, or aggressive medical procedures. Moreover, given that in most cases, VAE is the only solution to end the patient's sufferings, there certainly has to be stronger objections to claim that VAE is never morally or legally permissible.

CHAPTER 3

SETTING THE STANDARDS

Arguing for the legalization of voluntary active euthanasia (VAE) and physician assisted suicide (PAS) as the "appropriate medical treatment" for certain cases under a well-defined guideline leads us to discussions about the existing legal practice of VAE and PAS, in order to mark the necessary conditions, which would prevent the process to include "inappropriate" patients and exclude "eligible" patients. Most objections against euthanasia, as I have stated in the previous section, point out the possible slippery slopes and abuses. By evaluating the current guidelines, we can eliminate these arguments and form a basis for future discussions. My aim in studying these regulations and controversial conditions is not to lay down a descriptive analysis of the relevant discussion. On the contrary my main purpose is to provide a normative foundation to build on proper regulations which will use the right means to form its conditions.

Although the most well-known case is the Netherlands with its "Termination of Life on Request and Assisted Suicide (Review Procedures) Act"

that permits both VAE and PAS, it is not the only example any more. Belgium with the "Belgian Act on Euthanasia" allows VAE, Oregon State with its "Death with Dignity Act" allows PAS, and Switzerland with Article 115 in its Constitution allows any type of assisted suicide without limiting the act to the medical area[54]. In this section, I focus on the problematic points of these guidelines and present the possible objections against them. By evaluating these conditions and objections, I discuss the idea of legalizing euthanasia and determining the right criteria to include the patients who fit the proper understanding of euthanasia. First, I start with defining the scope of patients that euthanasia should be available to. Using this scope, I go through a number of controversial conditions to evaluate whether they provide good criteria or not. These conditions are about "unbearable suffering", "constant and unbearable physical or mental suffering", "terminal disease", "no prospect of improvement", "no selfish motive", mental illness, and legal age for competency.

As I go through each of these condition, I argue that "constant and unbearable physical or mental suffering" is a more comprehensive condition which targets a better defined group of patients than the "unbearable suffering" condition. On the other hand, I show that criteria such as "terminal disease" and

[54] See Appendices for the complete forms of these regulations.

"no prospect of improvement" limit the scope of euthanasia in the wrong direction, where it excludes the patients who should be most eligible according to the aim of euthanasia. While regulating euthanasia for mentally ill patients and minors is very difficult, I claim that a proper guideline should include them as well. I argue that as a very crucial procedure, euthanasia should not be carried out under too wide conditions such as "no selfish motive".

Scope of Voluntary Euthanasia

The guidelines that I consider apply both to VAE and PAS. As we look at the proper understanding of voluntary euthanasia that I provided in the previous section, the definition holds both for VAE and PAS, since it does not focus on who carries out the last act. The main point of voluntary euthanasia is to provide a treatment that is performed when the patient's desires and values make it unbearable for him to live with certain medical conditions and when his request, which will lead to his death, is fulfilled in order to end his sufferings. These patients are;

1. patients in serious physical pain (e.g. cancer patients),

2. patients who have a serious incurable disease (e.g. AIDS/MS/ALS/Alzheimer's disease patients),

3. patients with serious irreversible damage (e.g. patients who have burns),

4. patients with mental illness (e.g. patients with long-term major depression).

Any patient who carries *any* of these characteristics should have the option of euthanasia available for her. In other words, any of these conditions are sufficient to be considered an eligible candidate for euthanasia. Of course, this does not mean that the act of euthanasia which is performed on a patient suffering from any of these conditions will necessarily be justified. In order for the procedure to be justified, the patient should go through a number of steps including verification of her competence and consultation with other doctors to explore every other possible treatment. There can be cases where the patient falls between these categories, but these categories are only to determine the main groups of patients that any regulation should include. Patients who do not exactly fit one of those categories should be evaluated case by case with the help of an explicitly stated guideline.

Unbearable Suffering

To start with, the first controversial condition comes from the Netherlands' Termination of Life on Request and Assisted Suicide (Review Procedures) Act, which provides a guideline both for PAS and VAE. The criterion states that: "the attending physician must be satisfied that *the patient's suffering was unbearable*, and that there was no prospect of improvement"[55].

We can evaluate this condition in three parts by focusing on the notions of "suffering", "unbearable" and "no prospect of improvement". At this point, I discuss the first part of the article, which is about "unbearable suffering" and turn back to the third part, i.e. "no prospect for improvement", later on. Two main problems with "unbearable suffering" are that (1) there are no medical means to detect the patient's level of "suffering", and (2) there is no objective clear-cut definition for the term "unbearable". The decision for claiming that the patient has "unbearable suffering" totally depends on the patient's values and physician's judgment. I argue that although this is a subjective condition which seems to be open for abuses, it provides the necessary subjectivity that makes the euthanasia patient's choice.

[55] Dutch Ministry of Foreign Affairs. "Termination of Life on Request and Assisted Suicide (Review Procedures) Act", p. 3. Available [online]: http://www.minbuza.nl/binaries/en-pdf/pdf/euth-amendedbill-en.pdf [21 September 2007]

Starting from the first issue, the concept of "suffering" is problematic due to its nature. When a doctor examines the patient, she uses many objective criteria to judge his condition such as the disabilities, discomfort, and pain that his condition causes. However, when it comes to judging the level of "suffering" that the patient experiences, the physician has no fully objective means to check the validity of the patient's statement because "suffering" has many aspects apart from physical pain. The patient who is under a higher level of pain is not necessarily the one who is suffering most. One definition given by Webster's Dictionary states that suffering is "the bearing of pain, inconvenience, or loss; pain endured; distress, loss, or injury incurred; as, sufferings by pain or sorrow; sufferings by want or by wrongs"[56]. Hence, it is possible that a cancer patient who is in pain may suffer less than a quadriplegic who does not feel pain related to her condition, since suffering can have more sources than having pain. Since the concept of suffering is essentially connected to the patient's strength, values, pain threshold, and psychology, the physician can only guess at his patient's "suffering". However, considering that he can neither know the level of suffering nor use comparisons in order to make the right decision, he can never be certain.

In addition to the vagueness caused by the concept of "suffering", the term

[56] *Webster's Revised Unabridged Dictionary* (1913), s.v. "suffering".

"unbearable" is also hard to define because it strictly depends on the patient. The subjectivity of this condition brings the concerns about abuse and misuse. In case of two bone cancer patients, one patient who is in less pain and under better care may not handle her situation, while the other one who is in a later stage with more pain and no one to take care of her may not find the situation "unbearable". If we consider this condition from the physician's point of view, there is a serious risk of misjudgement, which makes it harder for physicians to be sure whether their patient was really eligible or not. The patient may not have "unbearable" suffering, but she may be temporarily depressed or in shock, which might have been treated by proper means, or in order to receive help for dying, she may lie to her physician.

However, accepting the subjectivity of this condition does not necessarily lead us to conclude that it should be excluded from guidelines. Since euthanasia is a decision that depends on the patient's choices, ideas, feelings, and condition, it necessarily has a subjective aspect and varies highly from one person to another. Yet, this subjectivity is not exclusive to euthanasia. When it comes to a highly risky but necessary heart surgery, the decision whether to continue with this invasive procedure or not depends on the patient's own ideals and values as well. Since it is a decision about the patient's own body and life, having a

subjective condition in the guideline does not necessarily mean that it is more open to abuse than any other invasive medical procedure. Turning back to the physician's situation, every crucial medical decision carries a great amount of risk for misjudgement. Many highly risky procedures result with unexpected negative consequences and since every patient is so different from each other, there does not seem to be a single right treatment in severe cases. In this sense, claiming that conditions for euthanasia are open to misuse or too subjective to reach to absolute decisions should not be an objection against it, considering that the various medical procedures share the same problem yet are regularly performed.

As we evaluate this condition, it is clear that it brings a considerable amount of subjectivity to the whole procedure. However, since by nature euthanasia already involves a certain amount of subjectivity, this condition does not cause an extra vagueness. Attempts to create a strict guideline aim to provide a number of objective criteria in addition to the subjective conditions. For that reason, the condition of "unbearable suffering" does not make the guideline loose, but it simply points to the personal and subjective side of euthanasia. Moreover, if we were to imagine leaving no personal criteria to the patient, then we are led to a situation where doctors decide who is considered to be suitable to

die and who is not on solely objective bases. Such an approach has more potential to cause even more problematic situations where some lives can be labelled as "unbearable" or "not worthy" even when the patient herself may not think her life "unbearable". Since we should not make such a categorization, it is reasonable to claim that we should also avoid coming up with completely objective rules to judge whether a patient is experiencing "unbearable suffering" or not.

Constant and Unbearable Physical or Mental Suffering

In Belgium's Act on Euthanasia, the Dutch condition of "unbearable suffering" is changed into:

> the patient is in a hopeless medical situation and is manifestly experiencing *constant and unbearable physical or psychological suffering* which cannot be alleviated and which is the result of an accident or a serious and incurable pathological condition[57]

This criterion is a more detailed version of the "unbearable suffering" condition. Since it narrows down the patients on the right basis, I argue that it is preferable to the previous one. There are two focal points, both of which may be

[57] World Health Organization, "Law of 28 May 2002 on Euthanasia". Available [online]: http://www.who.int/idhl-rils/results.cfm?language=english&type=ByTopic&strTopicCode=XIIA&strRefCode=Belg [21 September 2007]

controversial unless they are well defined, of this condition: (1) requiring "constant and unbearable suffering" and (2) accepting "physical or mental" suffering.

The first point is about the concept of "suffering". As I have stated, by definition suffering can be caused by various reasons including inconvenience, loss, sorrow or pain. Requiring "constancy" in addition to the "unbearableness" provides an elimination criterion for those who are experiencing temporary distress or depression caused by their medical condition. A patient who is informed about her incurable or irreversible condition or a patient who is experiencing a lot of pain may find her situation unbearable. Yet this does not necessarily mean that the patient will not go through an adjustment process, in which she may learn to cope with her condition from the aspects of psychological understanding and changes in life-style. For example, a patient who becomes paralyzed from the waist down may think that her life will have no meaning after that point but it may turn out that after overcoming the psychological trauma, she may find other ways to enjoy her life and by adjusting her environment –such as the house, the car– and her life-style –such as her job, her hobbies. For that reason, supporting the adjective "unbearable" with "constant" makes the conditions stricter with the right aim. However, a potential problem with this

condition may arise in case of conceptual confusion between "suffering" and "pain".

In many news articles on Belgium's legal regulations for euthanasia, the phrase "constant and unbearable physical and psychological *pain*"[58] is used. First of all, if we require "pain" for eligibility, then euthanasia becomes a treatment which can be used only when other treatments fail to alleviate the patient's pain and the scope of euthanasia turns out to exclude many patients whose *sufferings* cannot be alleviated if they are not experiencing uncontrollable pain. With such a condition patients with nervous system damage, such as quadriplegia or ALS, will not fall under the scope of euthanasia. On the other hand, in illnesses such as MS, the condition of the patient gets worse from time to time and it may improve for an uncertain amount of time. The pain of such patients is not constant since the sickness does not follow a linear way of development. However, all of these patients with such conditions may have constant and unbearable *suffering* since with or without the pain or linear development, their conditions may cause them to suffer unbearably and constantly.

While this criterion starts by providing a stricter condition for euthanasia by putting "constant" and "unbearable" together, it leaves a looser end by stating

[58] *BBC News*, "Belgium legalizes euthanasia", 16 May 2002.
The New York Times, "Euthanasia Law Approved", 17 May 2002.

that “physical *or* mental” suffering would qualify for euthanasia. Although I will evaluate the cases related to mental illness later on, it is clear that “mental suffering” is a problematic condition. The definition of suffering that I have provided earlier has already a non-physical aspect, but this aspect does not refer to the “mental” sufferings caused by “mental” problems. For example, an ALS patient cannot feel pain, therefore when we say that he is suffering, we refer to the “psychological” suffering that he is experiencing because of his “physical” condition. Even if the suffering itself is not as physical as pain; it is still caused by physical conditions. On the other hand, when “mental suffering” is specified, the notion also includes mental illnesses, where the cause of suffering itself is “mental”.

Compared to the concept of “suffering”, the meaning of “mental suffering” is even less clear. Even with a clear definition of what would qualify as a mental suffering, this condition can cause vagueness on one of the fundamental criteria for euthanasia in every guideline, and that criterion is competency. Mental suffering may affect competency. In this case, there should be a line between the kinds of mental suffering that would qualify as a reason for euthanasia and the other kinds that would fall under the category of mental illnesses which causes the patient to be claimed incompetent.

Considering all these discussions, I argue that requiring "constant" in addition to "unbearable" suffering is an effective way to exclude patients who are making such a crucial decision based on their "bad day" or "difficult period". On the other hand, accepting mental suffering as a reason for applying for euthanasia requires a very clear explanation of what is considered to be "mental suffering" and what kind of process the patients should go through in order to verify that their condition does not make them incompetent.

Terminal Disease

There are some conditions which provide objective bases for euthanasia guidelines. I argue that even though these conditions may be helpful for forming arguments against misuse, they are not that desirable in considering the aim of euthanasia. One such controversial condition is presented in Oregon's Death with Dignity Act as;

> An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a *terminal disease*, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.[59]

[59] Oregon State Department of Human Services, "Death with Dignity Act". Available [online]: http://egov.oregon.gov/DHS/ph/pas/ors.shtml [21 September 2007]

According to this condition, patients who are eligible for euthanasia must be in the terminal stage of illness. In Oregon's guideline, "terminal disease" is defined as; "…an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce *death within six months*"[60]. Claiming that terminal disease is a requirement for euthanasia, helps the whole idea of euthanasia to be more acceptable in the sense that the reason for performing euthanasia turns into hastening the process of dying and eliminating the pain caused by unavoidable and soon to be expected death. Although it is an objective way of judging the eligibility of the patient, this requirement excludes patients whose condition fit the aim of euthanasia. Therefore, "terminal disease" can only be considered as a sufficient condition for requiring euthanasia but not as a necessary condition to be met.

The real aim of euthanasia is to apply the "most appropriate treatment" to the patient's medical situation, which cannot be handled through any other medical process. Considering that many incurable and/or painful illnesses are not necessarily terminal, this condition leaves out many patients, whose medical situation fits to the proper understanding and aim of euthanasia. Medical conditions such as ALS cause the patient to have a long life without any prospect

[60] Ibid.

of getting better but going through the stages of the illness, which lowers his overall quality of life. As in the cases of Elizabeth Bouvia and Larry McAfee[61], who requested withdrawal of treatment in order to die, preventing patients who are not terminally ill from having their requests for euthanasia to be fulfilled is not compatible in practice with the aim of euthanasia. Seeing these cases resolved in favour of the patients, we can reasonably infer that since the law limiting withdrawal or withholding of treatment to terminal patients does not work in practice, there is no reason for us to believe that it will work for VAE and PAS.

Another problem with the terminal disease condition is predicting the exact time when the patient enters the terminal stage of his illness. As the physician waits for the latest stage of the illness to declare the patient terminal, either because of the severe symptoms of the illness (such as dementia) or heavy

[61] Elizabeth Bouvia was a 25 years old patient who was suffering from cerebral palsy, which caused her to become almost completely paralyzed, and was experiencing great pain caused by severe degenerative arthritis. She wanted to starve herself to death but the hospital, knowing her purpose, force-fed her. After several appeals to the court, she was granted the decision that "competent, adult patients have a constitutional right to refuse medical treatment in order to die". But after this decision, Elizabeth did not kill herself.
Larry McAfee was a 29 years old patient who became quadriplegic after a motorcycle accident. He lost almost all of his movement capacity and was connected to a ventilator. After filing suit in court for his right to die, he was provided with a mechanism which he could use to turn off his ventilator to kill himself. Since he previously made it clear that he did not want to die through disconnecting the ventilator because of his fear of suffocation, the judge also granted his "right to be free from pain at the time the ventilator is disconnected". After this decision, Larry did not kill himself.
(Pence, pp. 64–73.)

pain medication, the patient may lose his competency to be the primary decision-maker about his condition. In that case, even if the patient fulfils one condition, since he is incompetent, he can no longer request euthanasia.

The condition of "terminal disease" brings the discussion to a safer side where the arguments about killing patients who could have gotten well are prevented. Since the patients who are eligible for euthanasia have been declared to be terminally ill, except for miraculous recoveries the room for mistakes is considerably narrowed down. Yet when we turn back to the aim of euthanasia and what types of patients should be eligible for it, a "terminal disease" condition leaves many of them out. As for the list that I have stated at the beginning, none of these patients can have euthanasia as an option until they are declared to be terminal. This means neither patients who are suffering from uncontrollable physical pain, nor patients with incurable diseases, can request euthanasia until they are foreseen to live no longer than six months. For that reason, even though a "terminal disease" condition may seem like a good criterion to prevent abuses, it limits the scope of euthanasia so far that the proper understanding of euthanasia does not apply any more. Euthanasia becomes a procedure that only hastens death, instead of terminating the unbearable suffering of patients. Hence,

the condition cannot be included in a guideline which is build on the basis of "proper understanding of euthanasia".

No Prospect of Improvement

Avoiding the extremely narrow scope that the "terminal disease" condition causes, the Netherlands' Termination of Life on Request and Assisted Suicide (Review Procedures) Act uses a wider criterion with a similar idea. The criterion states that: "the attending physician must be satisfied that the patient's suffering was unbearable, and that there was *no prospect of improvement*"[62]. The term "no prospect for improvement" is a type of replacement for the condition of "terminal disease", and unlike the latter this condition includes the patients who are not terminal but who should be considered for euthanasia –such as ALS or MS patients. In other words, this condition makes the scope of euthanasia wider than requiring patients to be terminally ill, without getting dangerously close to patients who can get better. However it still remains too narrow when we evaluate the condition's efficiency in accordance to the list of patients who should have the option of euthanasia available to them.

[62] "Termination of Life on Request and Assisted Suicide (Review Procedures) Act", p. 3.

The condition "no prospect of improvement" aims to exclude the patients who have the potential to get better. The problem with this condition arises since it excludes patients not because they can get *well* but only because they can get *better*. Here, we can use the example of Dax Cowart. As a result of an accident, more than two-thirds of Dax Cowart's body was severely burned and irreparably damaged. His requests for refusal of treatment in order to die were turned down. Even though he remained blinded, disfigured, and disabled, after going through a long and painful treatment he acquired a respectively high quality of life, where he finished law school and got married. However, even after having all these things, he still insists that he should have been given the right to make his own decisions and doctors should have respected his wishes[63]. In his case, even though it was a low possibility, there still was a prospect of improvement, and he eventually recovered. However, as we evaluate this case in accordance to the proper understanding of euthanasia, the conclusion is that his situation should have been qualified.

In certain cases, where there is irreversible damage, the condition of the patient has a potential for improvement but this does not necessarily mean that after the treatment is completed, the quality of life will be acceptable for the

[63] Dax Cowart and Robert Burt, "Confronting Death Who Chooses, Who Controls?", *The Hasting Central Report* 28, no.1 (Jan.-Feb. 1998), pp. 14–21.

patient. As in Cowart's example, a patient with severe burns can recover to pursue a life that enables him to have a family and a good job, yet because of the accident, he remained blinded, handicapped and disfigured since his twenties. Now, Cowart says that he is happy with his life, but he strongly argues that he should not have been forced to bear with the procedure; and even with his current knowledge about his life after the recovery, he says that he still would have refused the treatment[64]. Considering all the aspects of the case, it should be concluded that it still depends on the patient to choose whether to put up with the treatment and whether such accomplishments make his life acceptable even though his body remains severely and irreversibly damaged. When the patient's condition is that severe, the treatment for recovery may require long and painful procedures. In Cowart's case, treatment for burns includes a very painful period of time with long lasting hospitalizations –more than one year– and several surgeries. Even if the result would have been predicted to include full recovery, forcing patients to undergo such a painful procedure conflicts with the patient's right to self-determination, which I have defined earlier as the right of every competent person to be the decision-maker about his own body and life.

[64] Ibid., pp. 17–18.

Given any case as severely irreversible as Cowart's, the criterion of "no prospect of improvement" prevents patients from requesting euthanasia on the basis that their condition can improve, even though (1) their life standard may never be acceptable for them and (2) the procedure for getting better requires enduring a high level of suffering. When the prospective life standard is not acceptable for the patient, then it is easier to claim that *no prospect of improvement* is a very narrow condition, considering that "improvement" does not necessarily refer to a good quality of life. On the other hand, in Diane's case, she had 25% chance for recovery with no severe handicaps left[65]. In her case, I argue that the decision whether to go through that long and painful treatment should still completely depend on the patient. Diane's treatment would include long hospitalizations, probable infectious complications resulting from chemotherapy, and bone marrow transplantation, which has also many side effects[66]. The question may be, if doctors let patients who have the chance to survive and lead a healthy life choose death, then will euthanasia become an option for every sick person whether she can survive or not? The line should be drawn in accordance to the medical standards and patient's standards. Medical standards should consider the life quality that the patient will have after the

[65] Quill, "Death and Dignity: A Case of Individualized Decision Making", p. 480.

[66] Ibid.

treatment –i.e. irreversible damage or constant medication with painful side effects– and the treatment that the patient has to go through –i.e. long hospitalizations, chances of survival, severe side-effects. It should be understood that the patient does not have a duty to go through heroic actions just because there is a possibility for partial or full recovery. The patient's standards determine whether the treatment or the quality of life in case of partial recovery is unbearable or not, and every competent patient who decides to refuse treatment should have the chance to die without suffering. Since every patient who claims to refuse life-saving treatment or act against the agreed medical opinion of his doctors is already examined for their competency, doctors already know that the patient who decides to request euthanasia is thinking clearly and rationally, knowing her condition and chances. Considering that these patients will be rational, it is not possible frequently to face extreme cases such as a person refusing to take the necessary medication for chickenpox and asking for help to die. However, there are cases where the patients refuse to go through simple blood transfusion, which will save their lives because of their beliefs –such as the cases of Jehovah's Witnesses[67]. Such cases should be evaluated specifically and

[67] Barry R. Furrow et al., ed. *Bioethics: Health Care Law and Ethics*, 3rd ed. (St. Paul: West Group, 1997), pp. 241–245.

the guideline can provide a main idea which can be interpreted by the experts for every different case, just as the judges interpret the law for every different case.

Voluntary euthanasia is essentially based on the patient's autonomy, which can be explained as "a defining property of all persons, which all persons possess independently of their specific beliefs and commitments"[68] In all of these cases, the common point is that unless the patient is found to be incompetent or not fully informed about her condition and unless her decision can harm others, then she should be the primary decision maker about her own body. The criterion "no prospect for improvement" makes the medical possibility of improvement of the patient's condition override the patient's autonomy, no matter how much suffering the treatment or the condition after the treatment will cause. Hence, as we evaluate these crucial problems that the "no prospect of improvement" condition leads to, it is reasonable to conclude that this condition leaves out patients who otherwise should have the chance to opt for euthanasia. Therefore, this condition should not be a necessary one.

[68] Andrew Fagan, "Challenging the Bioethical Application of the Autonomy Principle within Multicultural Societies", *Journal of Applied Philosophy* 21, no.1 (2004), p. 18.

No Selfish Motive

Arguing that euthanasia should be legalized usually comes with the argument that it should be legalized if and only if there is a well-formed guideline that can carefully regulate the euthanasia cases. The Swiss Penal Code brings a whole new perspective to this idea. Although VAE is considered as a crime by Article 114[69], assisted suicide is decriminalized with a highly wide scope. Article 115 of Swiss Penal Code[70] states that:

> anyone with a selfish motive who incites a person to commit suicide or who helps that person, to commit suicide, if the suicide is consummated or attempted, will be punished by a maximum of 5 years reclusion or imprisonment[71].

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[69] Die Bundesbehörden der Schweizerischen Eidgenossenschaft, „Schweizerisches Strafgesetzbuch“, Art. 114 (The Federal Authorities of the Swiss Confederation, “Swiss Criminal Law”, Article 114):
“Tötung auf Verlangen
Wer aus achtenswerten Beweggründen, namentlich aus Mitleid, einen Menschen auf dessen ernsthaftes und eindringliches Verlangen tötet, wird mit Freiheitsstrafe bis zu drei Jahren oder Geldstrafe bestraft.”
Available [online]: http://www.admin.ch/ch/d/sr/311_0/a114.html [21 September 2007]
English translation of the Article 114 by Dr Jerome Sobel in “Assisted Death”, p. 2: “Anyone who yields to an honorable motive, notably compassion, and who, when requested seriously and urgently by a person, bestows death on that person will be punished by imprisonment”.
Available [online]: http://www.exit-geneve.ch/ExitAD.pdf [21 September 2007]

[70] Die Bundesbehörden der Schweizerischen Eidgenossenschaft, Schweizerisches Strafgesetzbuch Art. 115 (The Federal Authorities of the Swiss Confederation, “Swiss Criminal Law”, Article 115):
“Verleitung und Beihilfe zum Selbstmord
Wer aus selbstsüchtigen Beweggründen jemanden zum Selbstmorde verleitet oder ihm dazu Hilfe leistet, wird, wenn der Selbstmord ausgeführt oder versucht wurde, mit Freiheitsstrafe bis zu fünf Jahren oder Geldstrafe bestraft.”
Available [online]: http://www.admin.ch/ch/d/sr/311_0/a115.html [21 September 2007]

[71] Jerome Sobel, “An Example of Assisted Suicide”, p. 3. Available [online]: http://www.exit-geneve.ch/Exempleoas.pdf [21 September 2007]

In other words, from the law itself it is understood that as long as there is no "selfish motive", assisted suicide is permitted[72]. Therefore, certain non-profit organizations have the legal status for that allows them to assist suicide[73] , even though the law applies to everyone whether physician or not[74].

This law basically creates a perfect example for the view that opponents of euthanasia defend, which is that the regulations will go loose over time and there will not be any strict control over such a crucial issue; and this will end up causing deaths to occur involuntarily or with unsuitable reasons. Given that the only legal restraint is "no selfish motive", it is understandable that almost anyone, whether mentally ill or not, or terminally ill or not, can use this law to get assistance without putting the "assistant" in danger. It can be shown that the organizations which are recognized by the government follow a carefully regulated guideline, but still any person who will be tried under the Swiss law for assisting suicide will be subject to this widely applicable law.

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[72] Jerome Sobel, "Switzerland and the Good Death", p. 2. Available [online]: http://www.exit-geneve.ch/Exitbmengl.pdf [21 September 2007]

[73] Swiss Federal Office of Justice. May 2007. "The various forms of euthanasia and their position in law" Available [online]: http://www.bj.admin.ch/bj/en/home/themen/gesellschaft/gesetzgebung/sterbehilfe/formen_der_sterbehilfe.html [21 September 2007]

[74] Swiss Academy of Medical Science, "Care of Patients in the End of Life", p. 6. Available [online]: http://www.samw.ch/docs/Richtlinien/e_RL_Lebensende.pdf [21 September 2007]

Although it seems that Switzerland's case forms real life evidence of how things can get out of guidelines and restrictions, there is a very important aspect of the issue. Article 115 is about assisted suicide, but it is not about *physician* assisted suicide. This assistance is provided by certain organizations such as EXIT, but it is not considered as a "medical act" by the Swiss Academy for Medical Sciences[75]. While defining the proper understanding of euthanasia, I have stated that the condition must result from a certain medical situation and the act should be carried by the physician or with the help of the physician. Although organizations like EXIT offer help only to patients who are suffering from "incurable disease with unbearable pain" or from a "disease that will inevitably lead to death or an unreasonable disability"[76], the law itself requires neither the person asking for assistance to be a patient nor the assistance to be given by the physician. Guided by such a law that widens the scope of assisted suicide, the act loses its medical character.

The main point of defining the act of euthanasia as an act that should only be applied to the patients by the physicians is to keep it strictly in the medical area. Swiss Law is not about any medical situation. Therefore, it is a regulation

[75] N. Bittel, H. Neuenschawander, and F. Stiefel, "*Euthanasia*: a survey by the Swiss Association for Palliative Care", *Supportive Care in Cancer* 10, no.4 (2002), p. 266.

[76] G. Bosshard et al., "Assisted suicide bordering on active euthanasia", *International Journal of Legal Medicine* 117, no. 2 (2003), p. 106.

that is concerned about suicide and assisted suicide, but not *physician* assisted suicide. Naturally, with its loose definition, it includes PAS as well, but this way of decriminalizing the act does not necessarily qualify as a "euthanasia regulation", since it has no restriction about the medical aspect of the act. On the other hand, the Swiss Academy of Medical Science claims that it is the doctor's personal decision whether to assist the patient's suicide or not. But in case of assistance, it is the doctor's responsibility to make sure that the patient is competent, not under any pressure, informed and "approaching the end of life"[77]. Still these conditions remain too wide to prevent abuses. For these reasons, the Swiss Law is not only open to abuse in assisted suicide, but it also brings many loopholes for misuse of voluntary euthanasia.

Mental Illness

As we go through the existing legal regulations and actions about euthanasia, Switzerland comes up with another very controversial decision. In 2007, a Swiss court allows mentally ill people to ask for assistance for suicide. This is the move where the arguments on slippery slope come out. The Swiss

[77] Swiss Academy of Medical Science, p. 6.

Court decision says that “it must be recognized that an incurable, permanent, serious mental disorder can cause similar suffering as a physical [disorder], making life appear unbearable to the patient in the long term”[78]. As it is reported, “patients suffering from serious mental illnesses will be required to demonstrate that the desire is not the "expression of a curable, psychiatric disorder" but a "well-considered and permanent decision" based on rational judgment”[79].

The biggest problem about this ruling is that in a way, it challenges the competency condition. There already are discussions about how to differentiate the rationality of the requests for euthanasia, since the patients’ “suicidal” approaches can be the result of the depression caused by their condition. This means that, although their motives differ, they can be considered as competent (or incompetent) as any other patient suffering from depression with suicidal tendencies[80]. Considering this, it is reasonable to claim that the discussions about determining the competency of mentally ill patients are much more controversial. For this reason, the worry is that after passing such a law, people who are in

[78] *International Herald Tribune*, “Swiss high court ruling opens possibility of assisted suicide for mentally ill”, 2 February 2007.

[79] *JURIST*, 3 February 2007. “Swiss court extends physician-assisted suicide to incurable mental patients”. Available [online]: http://jurist.law.pitt.edu/paperchase/2007/02/swiss-court-extends-physician-assisted.php [21 September 2007]

[80] N. Gregory Hamilton and Catherine Hamilton, “Competing Paradigms of Responding to Assisted-Suicide Requests in Oregon: Case Report”. Available [online]: http://www.pccef.org/articles/art28.htm [21 September 2007]

severe depression may qualify for euthanasia. In the case of a severely and incurably depressed person, there is always a possibility that he may falsely seem to make perfect sense in his reasoning and can cause the experts to believe that he is competent, as well as the possibility that he is judging his condition rationally in spite of the depression. When it comes to making such an important decision, the possibility of making a mistake becomes very dangerous, since it may turn out that with the right treatment, the patient may recover from the depression and realize that it was his psychological problem that made him choose that direction.

In order to determine whether this ruling should be included in a guideline for euthanasia, we should again evaluate the relevant cases in accordance to the proper understanding of euthanasia. We can take the case of a 66 year old patient who has been

> suffering since age 17 from recurrent major depressive episodes with comorbid ano-rexia nervosa and obsessive-compulsive disorder. She was only free of any depressive symptoms during one year twenty years prior to the reported treatment course. The patient had to retire from work and got a full pension because of her incapacity to work as a secretary due to the major depression 6 years later. The current episode of depression started 5 years ago, after a short period of partial remission lasting several months only[81].

[81] Markus Kosel et al., "Magnetic Seizure Therapy Improves Mood in Refractory Major Depression", *Neuropsychopharmacology* 28, no.11, pp. 2045–2048.

This is an example of a mental condition that makes the patient suffer both physically and psychologically for a very long period of time. It prevents the patient from pursuing a normal life. When such a patient requests euthanasia, the decision process becomes very difficult. It is clear that the patient's desires and values can make it unbearable for her to live with this medical condition and the act of euthanasia would be performed in order to end her sufferings, which could not have been terminated by any other means over the years. Her sufferings seem as severe as any physical problem; hence euthanasia can be the "right treatment" for her condition. Every argument that applies for a physically suffering patient seems to apply for her as well.

The question of competency may seem blurred and difficult to establish in cases that involve mental illness. On the other hand, we cannot claim that typical cases of euthanasia are free from any psychological distress. Patients who conclude that their medical condition leaves them no prospect to attain the kind of life that fits their desires and values, decide that it is better to end their suffering as soon as possible. These patients are most likely to have illnesses such as cancer, AIDS, MS, ALS, etc. Most of these patients reach this conclusion after being hospitalized for a certain amount of time and going through certain invasive treatments. Of course not every case necessarily has these

characteristics, but these form the majority. When such a patient is claimed to be competent, that does not mean that the patient does not have any sign of depression or any psychological problem. It can be expected that most of these patients need counseling in order to cope with their situation and most of them have serious psychological problems due to their medical condition. Therefore, we can claim that most euthanasia candidates are not free from all psychological trouble. What is important is whether they can make a reasonable decision that considers every available option in spite of their psychological distress.

To conclude, we can say that it is not acceptable to exclude every mentally ill patient if the aim is to make euthanasia available to the patients who are listed at the beginning. Since those patients experience unbearable suffering, they should have the chance to ask for euthanasia if they are found to be competent and if they fulfill all the necessary criteria for eligibility. The cases that involve patients who are suffering from incurable long term mental illnesses and found to be incompetent for rational decision making, fall under the category of involuntary euthanasia. Since in this study I narrow my scope to voluntary euthanasia, those cases fall beyond this work's scope. With no doubt, cases with mentally ill patients carry a considerable amount of risk, but as long as these patients are found to be competent by a committee of psychiatrists, they should

be entitled to have the option of euthanasia available for them, and in order to minimize the risk of misjudgments and abuses, the guideline to regulate voluntary euthanasia for mentally ill patients should be very detailed.

Minors

In Oregon's Death with Dignity Act, it is clearly stated that to be eligible for PAS the patient has to be "18 years of age or older"[82]. On the other hand, the Netherlands' Termination of Life on Request and Assisted Suicide (Review Procedures) Act allows minors over twelve years old to be eligible in accordance with certain criteria as follows:

> If the patient is a minor aged between sixteen and eighteen and is deemed to be capable of making a reasonable appraisal of his own interests, the attending physician may comply with a request made by the patient to terminate his life or provide assistance with suicide, after the parent or parents who has/have responsibility for him, or else his guardian, has or have been consulted. (Article 3)[83]
> If the patient is a minor aged between twelve and sixteen and is deemed to be capable of making a reasonable appraisal of his own interests, the attending physician may comply with the patient's request if the parent or parents who has/have responsibility for him, or else his guardian, is/are unable to agree to the termination of life or to assisted suicide. Subsection 2 shall apply *mutatis mutandis*.

[82] Oregon State Department of Human Services, "Death with Dignity Act".

[83] "Termination of Life on Request and Assisted Suicide (Review Procedures) Act", p. 3.

(Article 4)[84] [Subsection 2 is the basic criterion for euthanasia in the Netherlands].

In other words, if the patient is between the ages of sixteen and eighteen, then he can make his own decision given that the parents are involved in the process of decision making. So the patient's request has primary importance, whether or not supported by the parents. If the patient is between the ages of twelve to sixteen, then the parents' consent is required in principle[85]. In the case of the parents withholding or not being able to give consent, then the doctor may acts upon the patient's request given that "he is of the conviction that the patient can thereby be spared serious disadvantage"[86].

One of the basic objections against euthanasia of minors is that these young people may request euthanasia, without fully understanding the consequences and other available options. Ages from twelve to eighteen are almost the exact age group where people go through their adolescence and are bombarded with hormones that cause them to have emotional distress. Considering their young age and their hormonal situation, it is not easy to claim

[84] Ibid., p. 4.

[85] Dutch Ministry of Foreign Affairs. 2001. "Q & A Euthanasia: A Guide to the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act", pp. 11–12. Available [online]: http://www.minbuza.nl/binaries/en-pdf/pdf/faq-euth-2001-en.pdf [21 September 2007]

[86] Andre Janssen, "The New Regulation of Voluntary Euthanasia and Medically Assisted Suicide in the Netherlands", *International Journal of Law, Policy and the Family* 16 (2002) p. 265.

that their decisions will be based on reason or that their ideas will not change in the future, causing them to reconsider some of the options which seem unacceptable for the time being.

The first reply to this objection is based on factual data. According to the publication by the Dutch Ministry of Foreign Affairs about euthanasia, 90% of euthanasia requests are based on terminal cancer and this ratio holds among minor patients as well[87]. In that case, there is no question whether the minor patient would be changing his mind or not after reaching a certain maturity. Since his time is limited, the question of his eligibility depends solely on his current situation and his current reasoning. Since the physician has a duty to present every other possible treatment, there is no possibility of overlooking other options.

On the other hand, the problem remains if the case involves a minor patient with no terminal illness. In that case, I believe the situation should be considered under the same category as any non-urgent highly risky invasive procedure that is performed on a minor. We can use the example of serious spinal cord injuries. In certain cases, the damage can be repaired but there is a very high possibility that the surgery may leave the patient paralyzed or may have fatal results. In such

[87] "Q & A Euthanasia: A Guide to the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act", p. 11.

cases, even if he is a minor, it is the patient's decision with the consent or involvement of the parents, whether to pursue with such a surgery or wait until he becomes an "adult" so that he will have more definite values and desires, which will determine whether the risk is worth taking or not. As long as the physician presents every possible option and is convinced that the decision that is made by the patient is rational, then since the patient is the one who is suffering from his medical condition, it should be his choice to decide what should be done about his situation. With this analogy, the decision-making procedure for euthanasia should not be different than any risky or invasive medical treatment to a minor, and the Netherlands' guideline provides a reasonable way of controlling this procedure.

VAE vs. PAS

As I have stated in the beginning, these four countries provide regulations that are about either voluntary active euthanasia or physician assisted suicide. Netherlands's regulation includes both VAE and PAS, while Oregon and Switzerland only allows assisted suicide and Belgium only permits voluntary active euthanasia. This information raises the question whether both VAE and

PAS are necessary or whether every medical situation that fits the proper understanding of euthanasia can be handled by legalizing only one of them.

The idea of legalizing either one or both of these actions is highly determined by the characteristic of the country itself. As a country where the Catholic Church has a high influence, in Belgium, any form of suicide is more unacceptable than VAE, which can be seen as the “right treatment”. Since VAE takes the responsibility even one step further than PAS by making the physician perform the last act, it is understandable that for some countries, legalizing assisted suicide brings relatively fewer controversies.

To analyze the question whether one of VAE and PAS would be sufficient or not, we can use a hypothetical case. For an ALS patient who cannot use any muscles in his body other than the ones that move his eyeballs, there is no possibility of PAS since the last act of physician assisted suicide must be carried out by the patient himself. When we consider his case in accordance to the proper aim of euthanasia, his medical situation definitely fits the criterion and the patient should not be forced to remain alive only because the type of medical condition he has does not allow him to carry out the last act by himself. For such a case, it is apparent that the patient is stuck in his condition as long as the option of VAE is not available for him.

On the other hand, VAE may be the answer for both physically capable and incapable patients. Since it causes the immediate death of the patient, even if he is physically capable of committing suicide with the assistance of the physician, his request for ending his life can still be fulfilled through active euthanasia. But in that case, what is the use of eliminating the option of PAS? From the physician's point of view, VAE requires even more responsibility than PAS. Hence, it cannot be the physician's choice to go with active euthanasia if the patient simply wants assistance. When it comes to the patient's point of view, eliminating assistance for suicide does not bring any benefit for his well-being. Prescribing the necessary drugs and explaining the exact way of using them leave the patient the opportunity to decide on his timing of taking the drugs instead of setting a date with the doctor. Unless there is a strong argument explaining why PAS should remain criminal while VAE is legal, it is reasonable to conclude that both options should be present for the patient. Going back to Belgium's case, even if the law results from certain characteristics of the majority –such as being Catholics–, since providing the option does not force people to use this option, making VAE or PAS available should not cause a problem for the society. If the patient believes that committing suicide is unacceptable given his beliefs, then he can always choose to pursue VAE. For that reason, the law should not force

people to act in accordance to the characteristics of the majority and it should focus on providing the best treatment for the patient's medical problem with respect to his own values and beliefs.

Conclusion

Arguing for or against legalizing voluntary active euthanasia leads us to analyze the current situations and the guidelines of the countries that have already included VAE or PAS in their legal system. While evaluating these guidelines, opponents of euthanasia focus on problematic conditions which may provide loopholes for misuse or abuse, while the defenders of euthanasia focus on the current situation, claiming that these countries provide "solutions" for the serious medical conditions of their people. In order to understand whether legalizing euthanasia leads us necessarily to a slippery slope or not, we need to analyze those critical conditions to make sure whether they provide the right bases for the proper aim of euthanasia. By studying these guidelines thoroughly, we see that certain conditions such as "terminal disease" and "no prospect of improvement" provide too narrow a scope, while simply requesting "no selfish motive" remains too wide. On the other hand, even though conditions such as

“unbearable suffering” or criteria on mentally ill patients and minors are very controversial, they cannot be eliminated if the guideline serves for the purpose of providing the option of euthanasia for patients whose medical conditions and whose personal values leave them no other way out.

CONCLUSION

Throughout my thesis I have argued for the moral and legal permissibility of voluntary active euthanasia. My main point for this argument is to consider VAE necessarily as a medical procedure and as a treatment which does not have any replacement in many cases. The moral value of VAE, as any other medical procedure, depends on whether it is done as the "most appropriate treatment" or not. For that reason, I argue against the idea that VAE is always morally impermissible and I claim that it is morally right under certain circumstances.

There are many arguments against euthanasia on the basis of incompatibility of principles –such as the conflicts between the Hippocratic Oath and euthanasia, or right to live and euthanasia– and on the basis of possible slippery slopes. I have evaluated the most important arguments among them and have shown that euthanasia does not provide a greater danger or conflict than many of the existing procedures in medicine. Moreover, given the proper understanding and aim of euthanasia, it can be reasonably argued that there are no solid conflicts between the principles. As I have shown, euthanasia aims to relieve the unbearable suffering of the patient and the majority of these patients are desperate because of the insufficiency of medicine in their cases. The lack of

availability of euthanasia causes these patients to be abandoned by the medicine or to be subject to procedures they find unbearable. On the other hand, acknowledging the needs of these patients and carefully regulating the procedure by a strict guideline enables the patients to be "cared" and the authorities in medical and legal areas to be in control of the situation.

As I have mentioned several times throughout my thesis, the legalization of VAE should be acceptable only with the condition of a strict commitment to a clear and detailed guideline. Therefore, to actualize the legalization of VAE, further studies on necessary and sufficient conditions about the eligibility of patients and on exact steps to be followed by the medical staff should be made. By evaluating the controversial conditions of the existing guidelines, I have given a basis for normative discussions on the formation of a complete regulation.

Considering the rate of improvement that occurred in the past 50 years in the medical area, it is reasonable to expect that human interference will gain more and more significance on the life-span and on the timing and manner of dying. For that reason, just as we embrace the procedures developed to save lives or improve the quality of lives of the patients, we should also acknowledge the

responsibility of the negative sides of medical developments and adjust our legal system and moral understandings in accordance.

APPENDIX A

THE NETHERLANDS' TERMINATION OF LIFE ON REQUEST AND ASSISTED SUICIDE (REVIEW PROCEDURES) ACT

Lower House of the States General

1998-1999 session

26 691

Review procedures for the termination of life on request and assisted suicide and amendment of the Criminal Code and the Burial and Cremation Act (Termination of Life on Request and Assisted Suicide (Review Procedures) Act)

No. 1

ROYAL MESSAGE

To the Lower House of the States General

We hereby forward for your consideration a Bill on review procedures for the termination of life on request and assisted suicide, and amending the Criminal Code and the Burial and Cremation Act (Termination of Life on Request and Assisted Suicide (Review Procedures) Act).

The explanatory memorandum which accompanies the Bill sets out the considerations on which it is based.

We hereby commend you to God's holy care.

The Hague, 6 August 1999

Beatrix

No. 2

ACT

We Beatrix, by the grace of God Queen of the Netherlands, Princess of Orange-Nassau, etc., etc., etc.

Greetings to all who shall see or hear these presents! Be it known:

Whereas We have considered that it is desirable to include in the Criminal Code grounds for granting immunity to a physician who, acting in accordance with the statutory due care criteria laid down in this Act, terminates life on request or provides assistance with suicide, and also that it is desirable to create a statutory notification and review procedure;

We, therefore, having heard the Council of State, and in consultation with the States General, have approved and decreed as We hereby approve and decree:

CHAPTER I. DEFINITIONS

Section 1

For the purposes of this Act, the following definitions shall apply:

a. Our Ministers: the Minister of Justice and the Minister of Health, Welfare and Sport;
b. assisted suicide: intentionally helping another person to commit suicide or providing him with the means to do so as referred to in article 294, paragraph 2, second sentence, of the Criminal Code;
c. the attending physician: the physician who, according to the notification, has terminated life on request or has provided assistance with suicide;
d. the independent physician: the physician who has been consulted about the attending physician's intention to terminate life on request or to provide assistance with suicide;

e. the care providers: the persons referred to in article 446, paragraph 1, of Book 7 of the Civil Code;
f. the committee: a regional review committee as referred to in section 3;
g. regional inspector: a regional inspector employed by the Health Care Inspectorate of the Public Health Supervisory Service.

CHAPTER II. DUE CARE CRITERIA

Section 2

1. In order to comply with the due care criteria referred to in article 293, paragraph 2, of the Criminal Code, the attending physician must:

a. be satisfied that the patient has made a voluntary and carefully considered request;
b. be satisfied that the patient's suffering was unbearable, and that there was no prospect of improvement;
c. have informed the patient about his situation and his prospects;
d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient's situation;
e. have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to in a. to d. above; and
f. have terminated the patient's life or provided assistance with suicide with due medical care and attention.

2. If a patient aged sixteen or over who is no longer capable of expressing his will, but before reaching this state was deemed capable of making a reasonable appraisal of his own interests, has made a written declaration requesting that his life be terminated, the attending physician may comply with this request. The due care criteria referred to in subsection 1 shall apply *mutatis mutandis*.

3. If the patient is a minor aged between sixteen and eighteen and is deemed to be capable of making a reasonable appraisal of his own interests, the attending physician may comply with a request made by the patient to terminate his life or provide assistance with suicide, after the parent or

parents who has/have responsibility for him, or else his guardian, has or have been consulted.

4. If the patient is a minor aged between twelve and sixteen and is deemed to be capable of making a reasonable appraisal of his own interests, the attending physician may comply with the patient's request if the parent or parents who has/have responsibility for him, or else his guardian, is/are unable to agree to the termination of life or to assisted suicide. Subsection 2 shall apply *mutatis mutandis*.

CHAPTER III. REGIONAL REVIEW COMMITTEES FOR THE TERMINATION OF LIFE ON REQUEST AND ASSISTED SUICIDE

Division 1: Establishment, composition and appointment

Section 3

1. There shall be regional committees to review reported cases of the termination of life on request or assisted suicide as referred to in article 293, paragraph 2, and article 294, paragraph 2, second sentence, of the Criminal Code.

2. A committee shall consist of an odd number of members, including in any event one legal expert who shall also chair the committee, one physician and one expert on ethical or moral issues. A committee shall also comprise alternate members from each of the categories mentioned in the first sentence.

Section 4

1. The chair, the members and the alternate members shall be appointed by Our Ministers for a period of six years. They may be reappointed once for a period of six years.

2. A committee shall have a secretary and one or more deputy secretaries, all of whom shall be legal experts appointed by Our Ministers. The secretary shall attend the committee's meetings in an advisory capacity.

3. The secretary shall be accountable to the committee alone in respect of his work for the committee.

Division 2: Resignation and dismissal

Section 5

The chair, the members and the alternate members may tender their resignation to Our Ministers at any time.

Section 6

The chair, the members, and the alternate members may be dismissed by Our Ministers on the grounds of unsuitability or incompetence or other compelling reasons.

Division 3: Remuneration

Section 7

The chair, the members and the alternate members shall be paid an attendance fee and a travel and subsistence allowance in accordance with current government regulations, insofar as these expenses are not covered in any other way from the public purse.

Division 4: Duties and responsibilities

Section 8

1. The committee shall assess, on the basis of the report referred to in section 7, subsection 2 of the Burial and Cremation Act, whether an attending physician, in terminating life on request or in assisting with suicide, acted in accordance with the due care criteria set out in section 2.

2. The committee may request the attending physician to supplement his report either orally or in writing, if this is necessary for a proper assessment of the attending physician's conduct.

3. The committee may obtain information from the municipal pathologist, the independent physician or the relevant care providers, if this is necessary for a proper assessment of the attending physician's conduct.

Section 9

1. The committee shall notify the attending physician within six weeks of receiving the report referred to in section 8, subsection 1, of its findings, giving reasons.

2. The committee shall notify the Board of Procurators General of the Public Prosecution Service and the regional health care inspector of its findings:
    a. if the attending physician, in the committee's opinion, did not act in accordance with the due care criteria set out in section 2; or
    b. if a situation occurs as referred to in section 12, last sentence, of the Burial and Cremation Act. The committee shall notify the attending physician accordingly.

3. The time limit defined in the first subsection may be extended once for a maximum of six weeks. The committee shall notify the attending physician accordingly.

4. The committee is empowered to explain its findings to the attending physician orally. This oral explanation may be provided at the request of the committee or the attending physician.

Section 10

The committee is obliged to provide the public prosecutor with all the information that he may require:
(1) for the purpose of assessing the attending physician's conduct in a case as referred to in section 9, subsection 2; or
(2) for the purposes of a criminal investigation.

The committee shall notify the attending physician that it has supplied information to the public prosecutor.

Division 6: Procedures

Section 11

The committee shall be responsible for making a record of all reported cases of termination of life on request or assisted suicide. Our Ministers may lay down further rules on this point by ministerial order.

Section 12

1. The committee shall adopt its findings by a simple majority of votes.

2. The committee may adopt findings only if all its members have taken part in the vote.

Section 13

The chairs of the regional review committees shall meet at least twice a year in order to discuss the methods and operations of the committees. A representative of the Board of Procurators General and a representative of the Health Care Inspectorate of the Public Health Supervisory Service shall be invited to attend these meetings.

Division 7: Confidentiality and disqualification

Section 14

The members and alternate members of the committee are obliged to maintain confidentiality with regard to all the information that comes to their attention in the course of their duties, unless they are required by a statutory regulation to disclose the information in question or unless the need to disclose the information in question is a logical consequence of their responsibilities.

Section 15

A member of the committee sitting to review a particular case shall disqualify himself and may be challenged if there are any facts or circumstances which could jeopardise the impartiality of his judgment.

Section 16

Any member or alternate member or the secretary of the committee shall refrain from giving any opinion on an intention expressed by an attending physician to terminate life on request or to provide assistance with suicide.

Division 8: Reporting requirements

Section 17

1. By 1 April of each year, the committees shall submit to Our Ministers a joint report on their activities during the preceding calendar year. Our Ministers may lay down the format of such a report by ministerial order.

2. The report referred to in subsection 1 shall state in any event:
    a. the number of cases of termination of life on request and assisted suicide of which the committee has been notified and which the committee has assessed;
    b. the nature of these cases;
    c. the committee's findings and its reasons.

Section 18

Each year, when they present their budgets to the States General, Our Ministers shall report on the operation of the committees on the basis of the report referred to in section 17, subsection 1.

Section 19

1. On the recommendation of Our Ministers, rules shall be laid down by order in council on:
    a. the number of committees and their powers;
    b. their locations.

2. Further rules may be laid down by Our Ministers by or pursuant to order in council with regard to:
    a. the size and composition of the committees;
    b. their working methods and reporting procedures.

CHAPTER IV. AMENDMENTS TO OTHER LEGISLATION

Section 20

The Criminal Code shall be amended as follows.

A

Article 293 shall read as follows:

Article 293

1. Any person who terminates another person's life at that person's express and earnest request shall be liable to a term of imprisonment not exceeding twelve years or a fifth- category fine.

2. The act referred to in the first paragraph shall not be an offence if it is committed by a physician who fulfils the due care criteria set out in section 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, and if the physician notifies the municipal pathologist of this act in accordance with the provisions of section 7, subsection 2 of the Burial and Cremation Act.

B

Article 294 shall read as follows:

Article 294

1. Any person who intentionally incites another to commit suicide shall, if suicide follows, be liable to a term of imprisonment not exceeding three years or to a fourth-category fine.

2. Any person who intentionally assists another to commit suicide or provides him with the means to do so shall, if suicide follows, be liable to a term of imprisonment not exceeding three years or a fourth-category fine. Article 293, paragraph 2 shall apply *mutatis mutandis*.

C

The following shall be inserted in article 295, after “293”: , first paragraph,.

D

The following shall be inserted in article 422, after “293”: , first paragraph,.

Section 21

The Burial and Cremation Act shall be amended as follows.

A

Section 7 shall read as follows:

Section 7

1. The person who conducted the post-mortem examination shall issue a death certificate if he is satisfied that the death was due to natural causes.

2. If death was the result of the termination of life on request or assisted suicide as referred to in article 293, paragraph 2, or article 294, paragraph 2, second sentence, of the Criminal Code respectively, the attending physician shall not issue a death certificate and shall immediately notify the municipal pathologist or one of the municipal pathologists of the cause of death by completing a report form. The attending physician shall enclose with the form a detailed report on compliance with the due care criteria set out in section 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

3. If the attending physician decides, in cases other than those referred to in subsection 2, that he is unable to issue a death certificate, he shall immediately notify the municipal pathologist or one of the municipal pathologists accordingly by completing a report form.

B

Section 9 shall read as follows:

Section 9

1. The form and layout of the models for the death certificates to be issued by the attending physician and the municipal pathologist shall be laid down by order in council.

2. The form and layout of the models for the notification and the detailed report as referred to in section 7, subsection 2, for the notification as referred to in section 7, subsection 3 and for the forms referred to in section 10, subsections 1 and 2, shall be laid down by order in council on the recommendation of Our Minister of Justice and Our Minister of Health, Welfare and Sport.

C

Section 10 shall read as follows:

Section 10

1. If the municipal pathologist decides that he is unable to issue a death certificate, he shall immediately notify the public prosecutor by completing a form and shall immediately notify the Registrar of Births, Deaths and Marriages.

2. Without prejudice to subsection 1, the municipal pathologist shall, if notified as referred to in section 7, subsection 2, report without delay to the regional review committees referred to in section 3 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act by completing a form. He shall enclose a detailed report as referred to in section 7, subsection 2.

D

The following sentence shall be added to section 12: If the public prosecutor decides, in cases as referred to in section 7, subsection 2, that he is unable to issue a certificate of no objection to burial or cremation, he shall immediately

notify the municipal pathologist and the regional review committee as referred to in section 3 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

E

In section 81, first point, “7, subsection 1” shall be replaced by: 7, subsections 1 and 2.

Section 22

The General Administrative Law Act shall be amended as follows.
In section 1:6, the full stop at the end of point (d) shall be replaced by a semicolon, and a fifth point shall be inserted as follows:

e. decisions and actions to implement the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

CHAPTER V. CONCLUDING PROVISIONS

Section 23

This Act shall enter into force on a date to be determined by Royal Decree.

Section 24

This Act may be cited as the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

We order and command that this Act shall be published in the Bulletin of Acts and Decrees and that all ministries, authorities, bodies and officials whom it may concern shall diligently implement it.
Done at ... on ...
The Minister of Justice,
The Minister of Health, Welfare and Sport,
Lower House, 1998-1999 session, 26 691, Nos. 1-2

APPENDIX B

BELGIAN LAW OF 28 MAY 2002 ON EUTHANASIA

(Moniteur belge, 22 June 2002, No. 210, pp. 28515-28520)

Chapter I. General provisions (Sec. 2):

For the purposes of this Law, euthanasia means the act, practised by a third party, that intentionally ends a person's life at that person's request.

Chapter II. Conditions governing the procedure (Sec. 3):

The physician who practises euthanasia does not commit an offence:

- if he has ascertained that: the patient is of full age or is an emancipated minor, competent and fully aware at the time of making the request; the request has been made voluntarily, after due and repeated reflection, and is not the result of external pressure; the patient is in a hopeless medical situation and is manifestly experiencing constant and unbearable physical or psychological suffering which cannot be alleviated and which is the result of an accident or a serious and incurable pathological condition,

- and if he observes the conditions and procedures prescribed by this Law *(paragraph 1)*.

Without prejudice to any additional conditions that he might wish to impose on his intervention, the physician must, in advance and in every case:

1) inform the patient of his state of health and life expectancy, consult with the patient concerning his request for euthanasia and discuss with him the therapeutic possibilities that may still be considered and the possibilities offered by palliative care and the consequences thereof. He must arrive, together with the patient, at the conviction that there is no

other reasonable solution in his situation and that the patient's request is entirely voluntary;

2) assure himself of the persistence of the patient's physical or psychological suffering and of the latter's repeated wishes. To this end, he is to conduct several interviews with the patient, with a reasonable interval between each with respect to the development of the patient's condition;

3) consult another physician as to the serious and incurable nature of the patient's affliction, specifying the reasons for the consultation;

4) if there is a team of carers in regular contact with the patient, discuss the patient's request with the team or its members;

5) if it is the patient's wish, discuss the request with the close associates designated by the patient; and

6) ensure that the patient has had the opportunity to discuss his request with the persons he wished to meet*(paragraph 2)*.

If he is of the opinion that death is not an obvious outcome in the near future, the physician must also:

1) consult a second physician, psychiatrist, or specialist in the pathological condition concerned, specifying the reasons for the consultation; and

2) allow at least a month to elapse between the patient's written request and the act of euthanasia *(paragraph 3)*.

The patient's request must be officially recorded in writing. The document is to be drafted, dated, and signed by the patient himself. If he is not in a position to do so himself, his request may be recorded in writing by a person of full age of his choice who must not have any material interest in the patient's death. The document must be added to the medical file. The patient may cancel his request at any time, in which case the document is to be withdrawn from the medcial file and returned to the patient *(paragraph 4)*.

All requests made by the patient, as well as the steps taken by the attending

physician and their outcome, including the report(s) of the physicians(s) consulted, are to be regularly consigned to the patient's medical file *(paragraph 5)*.

Chapter III. Advance declaration (Sec. 4):

Every person of full age or emancipated minor may, for cases in which he would no longer be able to express his wishes, record in a written declaration, his wish that a physician perform euthanasia if that physician ascertains that he is suffering from an affliction resulting from an accident or a serious or incurable pathological condition, that he is unconscious, and that this situation is irreversible according to current scientific knowledge. The declaration, drawn up in accordance with prescribed procedure, may be withdrawn or adapted at any time.

A physician who practises euthanasia, following an advance declaration as referred to above, does not commit an offence if he ascertains that the patient is suffering from an affliction caused by an accident or a serious and incurable pathological condition and is unconscious and if this situation is irreversible according to the current state of scientific knowledge and if he observes the conditions and procedures laid down by this Law.

Chapter IV. The declaration (Sec. 5):

The physician who practises euthanasia is to duly complete and submit, within four working days, the registration document referred to in Sec. 7 to the Federal Control and Evaluation Commission referred to in Sec. 6 of this Law.

Chapter V. The Federal Control and Evaluation Commission (Secs. 6-13):

Details are given of the Commission's composition *(Sec. 6)*. The Commission is to draw up a registration document which is to be completed by the physician each time that he practises euthanasia. This document is to comprise two parts containing the information referred to *(Sec. 7)*. Details are given of the conditions governing the Commission's examination of the document *(Sec. 8)*. The Commission is to draw up for submission to the Legislative Chambers, within the deadline prescribed, a statistical report, a report containing a description and an evaluation of the implementation of this Law, and, if

appropriate, recommendations likely to lead to a legislative initiative and/or other measures concerning the implementation of this Law *(Sec. 9)*.

Chapter VI. Special provisions (Secs. 14-16):

The request and advance declaration of will as provided for in Secs. 3 and 4 of this Law do not have binding value. No physician is required to practise euthanasia. No other person is required to participate in an act of euthanasia *(Sec. 14)*. A person who dies as the result of an act of euthanasia performed in accordance with the conditions imposed by this Law is deemed to have died a natural death with regard to the fulfilment of contracts to which he was a party, in particular insurance contracts *(Sec. 15)*.

APPENDIX C

THE OREGON DEATH WITH DIGNITY ACT

Section 1: General Provisions

127.800 s.1.01. Definitions:

The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:
(1) "Adult" means an individual who is 18 years of age or older.
(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
(3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.
(4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
(5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
(6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.
(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;
(b) His or her prognosis;
(c) The potential risks associated with taking the medication to be prescribed;
(d) The probable result of taking the medication to be prescribed; and
(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 s.1.01; 1999 c.423 s.1]

Section 2: Written Request for Medication to End One's Life in a Humane and Dignified Manner

127.805 s.2.01. Who may initiate a written request for medication:

(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.

(2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability. [1995 c.3 s.2.01; 1999 c.423 s.2]

127.810 s.2.02. Form of the written request:

(1) A valid request for medication under ORS 127.800 to 127.897 shall be in

substantially the form described in ORS 127.897, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Services by rule. [1995 c.3 s.2.02]

Section 3: Safeguards

127.815 s.3.01.Attending physician responsibilities:

(1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;

(c) To ensure that the patient is making an informed decision, inform the patient of:

(A) His or her medical diagnosis;

(B) His or her prognosis;

(C) The potential risks associated with taking the medication to be prescribed;

(D) The probable result of taking the medication to be prescribed; and

(E) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control;

(d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;
(e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;
(f) Recommend that the patient notify next of kin;
(g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;
(h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to ORS 127.840;
(i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;
(j) Fulfill the medical record documentation requirements of ORS 127.855;
(k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and
(l)

(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, provided the attending physician is registered as a dispensing physician with the Board of Medical Examiners, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or
(B) With the patient's written consent:

(i) Contact a pharmacist and inform the pharmacist of the prescription; and
(ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.

(2) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate. [1995 c.3 s.3.01; 1999 c.423 s.3]

127.820 s.3.02. Consulting physician confirmation:

Before a patient is qualified under ORS 127.800 to 127.897, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision. [1995 c.3 s.3.02]

127.825 s.3.03. Counseling referral:

If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. [1995 c.3 s.3.03; 1999 c.423 s.4]

127.830 s.3.04. Informed decision:

No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in ORS 127.800 (7). Immediately prior to writing a prescription for medication under ORS 127.800 to 127.897, the attending physician shall verify that the patient is making an informed decision. [1995 c.3 s.3.04]

127.835 s.3.05. Family notification:

The attending physician shall recommend that the patient notify the next of kin of his or her request for medication pursuant to ORS 127.800 to 127.897. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason. [1995 c.3 s.3.05; 1999 c.423 s.6]

127.840 s.3.06. Written and oral requests:

In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending

physician no less than fifteen (15) days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request. [1995 c.3 s.3.06]

127.845 s.3.07. Right to rescind request:

A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under ORS 127.800 to 127.897 may be written without the attending physician offering the qualified patient an opportunity to rescind the request. [1995 c.3 s.3.07]

127.850 s.3.08. Waiting periods:

No less than fifteen (15) days shall elapse between the patient's initial oral request and the writing of a prescription under ORS 127.800 to 127.897. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under ORS 127.800 to 127.897. [1995 c.3 s.3.08]

127.855 s.3.09. Medical record documentation requirements:

The following shall be documented or filed in the patient's medical record:
(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;
(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;
(3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;
(4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;
(5) A report of the outcome and determinations made during counseling, if performed;
(6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to ORS 127.840; and
(7) A note by the attending physician indicating that all requirements under ORS 127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed. [1995 c.3 s.3.09]

127.860 s.3.10. Residency requirement:

Only requests made by Oregon residents under ORS 127.800 to 127.897 shall be granted. Factors demonstrating Oregon residency include but are not limited to:
(1) Possession of an Oregon driver license;
(2) Registration to vote in Oregon;
(3) Evidence that the person owns or leases property in Oregon; or
(4) Filing of an Oregon tax return for the most recent tax year. [1995 c.3 s.3.10; 1999 c.423 s.8]

127.865 s.3.11. Reporting requirements:

(1)

(a) The Health Services shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897.

(b) The division shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the division.

(2) The Health Services shall make rules to facilitate the collection of information regarding compliance with ORS 127.800 to 127.897. Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public.
(3) The division shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 s.3.11; 1999 c.423 s.9]

127.870 s.3.12. Effect on construction of wills, contracts and statutes:

(1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.
(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. [1995 c.3 s.3.12]

127.875 s.3.13. Insurance or annuity policies:

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. [1995 c.3 s.3.13]

127.880 s.3.14. Construction of Act:

Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 s.3.14]

Section 4: Immunities and Liabilities

127.885 s.4.01. Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions:

Except as provided in ORS 127.890:
(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.
(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.
(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(5)

(a) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider from participating in ORS 127.800 to 127.897 on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider's policy regarding participating in ORS 127.800 to 127.897. Nothing in this paragraph prevents a health care provider from providing health care services to a patient that do not constitute participation in ORS 127.800 to 127.897.

(b) Notwithstanding the provisions of subsections (1) to (4) of this section, a health care provider may subject another health care provider to the sanctions stated in this paragraph if the sanctioning health care provider has notified the sanctioned provider prior to participation in ORS 127.800 to 127.897 that it prohibits participation in ORS 127.800 to 127.897:

(A) Loss of privileges, loss of membership or other sanction provided pursuant to the medical staff bylaws, policies and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in ORS 127.800 to 127.897 while on the health care facility premises, as defined in ORS 442.015, of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(B) Termination of lease or other property contract or other nonmonetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in ORS 127.800 to 127.897 while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(C) Termination of contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in ORS 127.800 to 127.897 while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subparagraph shall be construed to prevent:

(i) A health care provider from participating in ORS 127.800 to 127.897 while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(ii) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions pursuant to paragraph (b) of this subsection must follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For purposes of this subsection:

(A) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider prior to the provider's participation in ORS 127.800 to 127.897 of the sanctioning health care provider's policy about participation in activities covered by ORS 127.800 to 127.897.

(B) "Participate in ORS 127.800 to 127.897" means to perform the duties of an attending physician pursuant to ORS 127.815, the consulting physician function pursuant to ORS 127.820 or the counseling function pursuant to ORS 127.825. "Participate in ORS 127.800 to 127.897" does not include:

(i) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(ii) Providing information about the Oregon Death with Dignity Act to a patient upon the request of the patient;

(iii) Providing a patient, upon the request of the patient, with a referral to another physician; or

(iv) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(6) Suspension or termination of staff membership or privileges under subsection (5) of this section is not reportable under ORS 441.820. Action taken pursuant to ORS 127.810, 127.815, 127.820 or 127.825 shall not be the sole basis for a report of unprofessional or dishonorable conduct under ORS 677.415 (2) or (3).
(7) No provision of ORS 127.800 to 127.897 shall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community. [1995 c.3 s.4.01; 1999 c.423 s.10]
Note: As originally enacted by the people, the leadline to section 4.01 read "Immunities." The remainder of the leadline was added by editorial action.

127.890 s.4.02. Liabilities:

(1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a Class A felony.
(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.
(3) Nothing in ORS 127.800 to 127.897 limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.
(4) The penalties in ORS 127.800 to 127.897 do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of ORS 127.800 to 127.897. [1995 c.3 s.4.02]

127.892 Claims by governmental entity for costs incurred:

Any governmental entity that incurs costs resulting from a person terminating his or her life pursuant to the provisions of ORS 127.800 to 127.897 in a public place shall have a claim against the estate of the person to recover such costs and reasonable attorney fees related to enforcing the claim. [1999 c.423 s.5a]

Section 5: Severability

127.895 s.5.01. Severability:

Any section of ORS 127.800 to 127.897 being held invalid as to any person or circumstance shall not affect the application of any other section of ORS 127.800 to 127.897 which can be given full effect without the invalid section or application. [1995 c.3 s.5.01]

Section 6: Form of the Request

127.897 s.6.01. Form of the request:

A request for a medication as authorized by ORS 127.800 to 127.897 shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.
I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.
I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.
I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.
INITIAL ONE:
_____ I have informed my family of my decision and taken their opinions into consideration.
_____ I have decided not to inform my family of my decision.
_____ I have no family to inform of my decision.
I understand that I have the right to rescind this request at any time.
I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur

within three hours, my death may take longer and my physician has counseled me about this possibility.
I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.
Signed: _____
Dated: _____
DECLARATION OF WITNESSES
We declare that the person signing this request:
(a) Is personally known to us or has provided proof of identity;
(b) Signed this request in our presence;
(c) Appears to be of sound mind and not under duress, fraud or undue influence;
(d) Is not a patient for whom either of us is attending physician.
_____ Witness 1/Date
_____ Witness 2/Date
NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.
[1995 c.3 s.6.01; 1999 c.423 s.11]

PENALTIES

127.990
[Formerly part of 97.990; repealed by 1993 c.767 s.29]

127.995 Penalties:

(1) It shall be a Class A felony for a person without authorization of the principal to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument or any other evidence or document reflecting the principal's desires and interests, with the intent and effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition and hydration which hastens the death of the principal.
(2) Except as provided in subsection (1) of this section, it shall be a Class A misdemeanor for a person without authorization of the principal to willfully alter,

forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the principal's desires and interests with the intent or effect of affecting a health care decision. [Formerly 127.585]

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